Clinical Lecture
ON
TUMOURS.

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BY RUSHTON PARKER, B.S., F.R.C.S.,
PROFESSOR OF SURGERY IN UNIVERSITY COLLEGE, LIVERPOOL.

THE word "tumour" is familiar throughout the scientific world. In English, French, and Italian the spelling differs only by a letter or two from that of the Latin "tumor," which is preserved unchanged in Spanish and by a large proportion of English-speaking persons. A tumour is a swelling or lump, and these three names are applied, in medical practice, to morbid conditions in which increase of size is a feature. Every enlargement is accordingly a tumour, which, on complete investigation, will invariably be found to be one of the following things:—

1. A *distortion* or *displacement:* as in a hernia, a fractured or dislocated bone, ruptured muscle or other organ, and in some congenital deformities. A *distension:* as an overfilled bladder, intestines, &c.; an aneurism, a varix, a hydrocele. In some such sense a hæmatoma or blood extravasation must often be considered.

2. An *obvious inflammation:* as in abscess, especially chronic; in rheumatic enlargement of bones, and other indurations.

3. A *local hypertrophy:* as in congenital enlarged toes or foot, congenital moles of the skin, elephantiasis, hyperostosis (?).

4. A *tumour proper.*

Though every tumour necessarily falls into one of the above four categories, it is by no means always easy, or even possible, to be certain which that category is. For various reasons, the many elaborate definitions that have been devised with the view of representing exclusively those new formations or neoplasms that are reckoned among tumours proper are unnecessary, since every specimen in the above list of morbid conditions is confessedly called a tumour in practice, both before and after recognition. They are, moreover, useless, since not one of those definitions successfully describes the fourth group in language that invariably excludes the other three.

1. In the first class a hernia, a dislocation, or an overdistended bladder are capable of certain distinction from tumours proper. Yet a hydrocele of the tunica vaginalis or spermatic cord is a pathological effusion of fluid into a cyst that should be empty or absent. Is it an accidental physiological "distension" of Class 1, or is it a well-ascertained "inflammation" of Class 2; or is it without ascertainable cause, and a form of cystic "tumour proper" of Class 4? Again, an atheromatous sebaceous tumour is physiologically due to retention and accumulation of sebaceous secretion, closing, over-distending, and thickening a cutaneous gland, converting it into a more or less globular cyst. It is confessedly regarded as a cystic variety of tumour proper; yet its causal resemblance to hydrocele is very close, and the distinction of either from an overfilled urinary bladder is one of degree rather than of kind.

2. Among "obvious inflammations," a chronic abscess and a glandular enlargement are capable of a recognition, that if not clinically easy or immediate is ultimately certain on dissection. A fluid distension of a patellar or other bursa is a purely inflammatory phenomenon, which subsides on the application of suitable treatment, with or without previous evacuation; yet a fibrous thickening of the same bursa, though equally of inflammatory origin, may fail to disappear on the removal of irritation. There is something of the nature of "hypertrophy" in the increase of fibre-growth or production; though for all essential purposes it is called a tumour proper. Yet the clinical features and many of the pathological phenomena of certain tumours called malignant partake so strongly of the inflammatory type as to call for detailed comparison presently under the proper head.

3. Enlargement of bone, the obvious effect of inflammation, and similar enlargements called hypertrophy or hyperostosis, are constantly and inseparably blended with bony "tumours proper," from which they cannot always be distinguished, and with which they must often be identified. Is a pedunculated exostosis, produced by acrogenous ossification of its cartilaginous tip, an instance of "displacement," in the period of growth, of a fragment of epiphysal ossifying cartilage? Is it an example, in addition, of "hypertrophy" of cartilage, of bone, or of both? or is it, when finished, a "tumour proper," whether as a pedunculated exostosis, or as a great "enchondroma" with so proportionally inconsiderable a bony pedicle as hardly to suggest its similar origin and mode of growth? Who is to say? Except obvious inflammation, all the above categories may claim it.

4. Tumours proper are of many kinds, and must be classified for systematic discrimination, and for the mutual assistance of observers. Such arrangement as may be from time to time adopted for this purpose depends upon a variety of considerations, summed up in the purport and ultimate result of a tumour in its natural course, or in that modified by interference. Some tumours give little or no inconvenience, being harmless excrescences when situated in parts ordinarily concealed by the clothing, or, if exposed, being at worst unsightly. Others that may be painless are inconvenient deformities, whether concealed or exposed, attaining an excessive size and weight, the physical incubus of which is scarcely mitigated by an associated slowness of growth. But pain, though generally, is not always absent from otherwise non-injurious tumours, and those that are painful happen to be usually small and sometimes diminutive, not seldom suggesting, from their situation in or beneath the skin, the probable entanglement of nervous filaments. The situation of an otherwise harmless growth, as, for instance, beneath the tongue, in the orbit, or displacing the windpipe, may imperatively demand its removal. Finally, the skin over an innocent tumour now and then becomes ulcerated, with risk or loss to life through hæmorrhage or blood-poisoning. Such catastrophes are but indirectly associated with the morbid growth, and are, in fact, more or less accidental complications, which may accordingly be avoided.

These, then, are the attributes of benignancy, as contrasted with those of malignancy, next to be considered. All tumours proper are either benignant or malignant. The former are local abnormalities that have no inherent tendency to endanger life, and frequently fail to inconvenience their possessor; while the latter, though occasionally perfectly curable by operative removal, are always dangerous, and, though often temporarily checked with the effect of prolonging life, are only too frequently rapidly or hopelessly fatal. The size of a malignant tumour may be little or no guide to its nature, or measure of its danger. Rapidity of growth, however, is an almost constant feature, rendering them all conspicuous, and giving to their proportions, if at all huge, a significance that is sometimes appalling. There is a special inveteracy in their growth, evinced in varying degrees and modes—(*a*) Ulceration of the integuments, over malignant growths, is a conspicuous though not invariable feature. The attendant exhausting complications, blood-poisoning, hæmorrhage, and pain, though often as adventitious as in their more exceptional occurrence in the benign, assume by their frequency quite an integral importance. (*b*) A liability to reappear near the seat of removal, even after what has seemed to be thorough excision; suggesting the neighbouring existence of infective particles which, though undiscovered by the naked eye and microscope alike, are still suspected to imbue the tissues or fluids. (*c*) An infective spread to, and inveterate infiltration of, the lymphatic glands pertaining to, and draining, the seat of primary growth. (*d*) A dissemination in viscera, serous membranes, or subcutaneous and interstitial connective tissues, of tumours identical in most particulars with a primary original growth, which latter, though almost invariably obvious, occasionally eludes discovery. These disseminations are believed to be embolic, the infective particles being conveyed in the blood-stream and lodged in the arterial or capillary system, growing into tumours after their arrest. Some evidence is circumstantially furnished in the form of

thrombi, composed of the tissue of malignant tumours, that are sometimes found filling neighbouring veins of various sizes visible to the naked eye, and that may be often presumed to similarly invade smaller veins that are not thus visible. Microscopic investigation has, moreover, revealed the actual presence of malignant emboli, impacted in minute afferent bloodvessels of viscera; proving to demonstration both the fact of conveyance and its mechanism.

Now, ulcerated swellings of the lip or tongue, the face or cheek, skin, or mucous membrane, due to cancerous invasion, to syphilitic infection, or to non-specific inflammatory induration, have resemblances conspicuous and puzzling to all, sometimes temporarily misleading the ripest experiences, and therefore undeniably real. The clinical import, various in name and in course, is eventually clear in most instances, but the anatomical comparison, pushed to its furthest histological limits, not merely confirms the characteristics of divergence, but clenches the identity in points of resemblance. A simple inflammatory induration subsides on the discontinuance of the physical irritative cause, a specific infection of syphilitic influence as truly disappears by exactly similar means, or by the organic administration of a constitutional chemical antidote, or by both. The physiological aberration in simple inflammation, due to the irritation of mechanical agency, is reproduced in the infective forms, where the irritative effects of a specific virus, as a parasitic organism, when known at all, are chemically and otherwise manifested. Such are the exudations of pyæmia, of syphilis, of tubercle. The visible products of malignant disease suggest comparison with those of infective inflammation. They are more luxuriant than the simple inflammations, but incapable of undergoing absorptive resolution on the removal of irritation. They are exempt from suppuration, except, apparently, in the added complication of putrid irritation, but are amenable to no ascertained system of antidotal medication, and share with tubercle the necessity of removal as the sole accessible means of practical cure. They appear, especially in the case of some sarcomata, to partly owe their commencement, mysteriously but almost undeniably, to the operation of local injury, in which respect "acute traumatic malignancy" resembles infective inflammation, such as acute necrosis and, perhaps, caseous tubercle of bone. In anatomical structure malignant tumours conform largely, and often strictly, with inflammatory type; in superficial features, in physiological infection, and in much of their clinical inveteracy, they resemble products of known parasitic agency. There lacks only the discovery of a visible parasite to complete the analogy.

Classification of Tumours proper.

Accumulated observations of the external appearances, general behaviour of tumours, their localities, physiological development and anatomical structure have resulted in attempts at classification, truly reputable in their day, but necessarily changing with the advance of knowledge, and proving eventually more or less unsatisfactory in phraseology, if not in fact. The diseases remain the same if their names have been changed, though by fresh discoveries they seem sometimes to be multiplied, at others to be reduced in number. Some of the names, too, have undergone changes of meaning; so former terms and their previous significations must be noticed for purposes of interpretation. Among benign tumours the names explain themselves and their possible synonyms; it is in a portion of the malignant series that confusion has arisen. The classification of tumours according to their anatomical structure, associated with the name and times of John Abernethy, was a memorable step in naked-eye procedure. The refinements of the same principle, effected in the microscopic era, have celebrated the name of Virchow and of his contemporaries at home and abroad. The resolute appreciation of all clinical features, and a refusal even to admit anatomical distinctions except in subordination to the former, are at once most conspicuous characteristics of the example and teaching of Billroth, and a tribute to all that is excellent in cultivated empiricism. By employing two methods of classification in alliance, instead of preferring or excluding either, there has latterly resulted a systematic arrangement of all tumours proper, the malignant apart from the benign, assorted in anatomical sequence. The best statement of this kind is probably that which appeared in 1877, in the seventh edition of Erichsen's Surgery, found also in all essential outlines in the subsequent edition of Green's Pathology, and of Holmes' smaller work. The following table is prepared, with slight alterations, from Erichsen's account.

Benign tumours are divided into—

I. Cystic tumours in general.
- (1) retention cysts.
  - A. In glands or their ducts.
    - Cutaneous (sebaceous), as wens or atheromatous tumours, including "horns."
    - Mucous (mouth, vagina, &c.):
      - Glands of Bartholin—Cysts of vulva.
      - Glands of Cowper—Male perineal cysts.
    - Larger glands:
      - Salivary—Ranula.
      - Mammary—Simple cysts.
  - B. In ductless glands or cavities.
    - Bursæ — Hydrocele, housemaid's knee, bunion.
    - Sheaths of tendons, ganglion — Liquid, fibrinous, fibrous.
    - Ovary or thyroid gland—Simple cysts.
- (2) Newly formed closed cysts.
  - A. Dermoid, congenital tumours.
    - (*a*) Sebaceous, placed away from seat of sebaceous glands.
    - (*b*) Ditto, with wall of true skin structures, glands, hair, &c.
    - (*c*) Containing teeth, bone.
  - B. Serous, simple cysts.
    - Congenital, as hydrocele of neck or shoulder.
    - Arising in solid tumours.
  - C. Proliferous, compound cysts, of ovary and elsewhere.
  - D. Blood-cysts—Hæmatoma, hæmatocele.
    - (The same occurring in solid tumours.)
  - E. Parasitic cysts—Hydatids.

II. Tumours composed of one of the modifications of fully developed connective tissue.
- Fat—Lipoma.
- Fibrous tissue—Fibroma.
- Mucous tissue, like that of umbilical cord or vitreous humour—Myxoma.
- Cartilage—Chondroma, enchondroma.
- Bone—Osteoma, exostosis.
- Tooth—Odontoma.

III. Tumours which resemble in structure, more or less perfectly, one of the more complex tissues of the body.
- Muscle — Myoma, myofibroma, as in uterus, prostate, &c.
- Nerve—True neuroma.
- Blood-vessels — Angioma, nævus, also called cavernous or erectile tumours.
- Lymph-vessels—Lymphangioma.
- Lymph glands—Lymphadenoma.
- Papillæ (of skin or mucous membrane)—Papilloma, or wart.
- Secreting glands—Adenoma.
- A. Myeloid tumour of bone (*see* Sarcomas).

Malignant tumours are divided into—

IV. Sarcomas, or tumours composed of tissue which is either purely embryonic, or is undergoing one of the primary modifications seen in the development of adult connective tissue. Arising in connective-tissue layers and interstitial spaces, such as fasciæ, periosteum, bone, marrow, adipose tissue, corium, submucous tissue, the framework of secreting glands, and lymph glands.

Present names.	Older names.
A. Myeloid or giant-celled sarcoma. (This variety alone is non-malignant.)	Myeloid, fibro-plastic tumours (in some cases).
B. Spindle-celled sarcoma. Fasciculated sarcoma.	Fibro-plastic tumour (as generally understood). Recurring fibroid.
B*. Spindle celled melano-sarcoma. Or Melanotic } Spin.-celled Or Pigmented } sarcoma.	Melanosis, melanotic cancer, fungus hæmatodes.
C. Round-celled sarcoma. Alveolar sarcoma. Fibro-sarcoma. Lympho sarcoma and malignant lymphadenoma.	Encephaloid cancer. Medullary sarcoma or cancer.

Round-celled melano-sarcoma.		Melanosis, melanotic cancer, fungus hæmatodes.
Melanotic Pigmented	Round-celled sarcoma. Alveolar sarcoma.	
Myxosarcoma.		Probably often called colloid cancer.

V. Carcinomas, or tumours composed of cells of an epithelial type, arranged in spaces in a stroma consisting of more or less perfectly developed fibrous tissue. Arising in and consisting largely of cutaneous, mucous, or glandular epithelium.

A. Cutaneous epithelioma of skin.
Cutaneous epithelioma of lip, anus, &c.
Cutaneous epithelioma of prepuce, glans penis, vulva, &c.

B. Mucous epithelioma of tongue, gums, mouth, fauces, gullet.
Mucous epithelioma of stomach, intestine.

C. Glandular cancer of breast, pancreas, and other glands.

Sarcomas of Bone.

Any of the malignant sarcomas may arise in the fibrous covering of bones, their names being then preceded by the additional word "periosteal." Or they may arise in the central fat, whether of cancelli or of tubular marrow. In any of these central tumours may be found giant-cells or myeloplaques; sometimes so abundantly as to give the growth a resemblance to ordinary myeloid, microscopically, though differing in all other respects. The following sarcomas are peculiar to bone, and may be of either central or periosteal origin: osteoid chondro-sarcoma, osteo-sarcoma or ossifying sarcoma, both otherwise known as osteoid cancer. Carcinoma never arises primarily in any bone, but invades it secondarily either by contiguous spread from another primary source (as skin, tongue, mammary gland, &c); or as a reproduction by distant conveyance in the circulating fluids.

Mammary Tumours.

I. Benign.
(*a*) Cysts.

(1) Simple	Unilocular. Multilocular.	
(2) Adenoceles. Cystic adenofibroma. Cystic adenomyxoma. Cystic adenosarcoma.		Other names: Chronic mammary tumours, sero-cystic tumours.

(3) Parasitic hydatids (rare).
(*b*) Simple tissue tumours (rare curiosities).
Lipoma, chondroma, osteoma.
(*c*) Adenomas, and pure hypertrophies.
(1) Non-cystic adenofibroma of young women.
(2) Simple general hypertrophy.
(3) Simple local hypertrophy.
Acinous adenoma.
Tubular adenoma.

II. Malignant.
(*d*) Sarcomas.

Round-celled sarcoma. Spindle-celled sarcoma. Myxosarcoma. Alveolar melanosarcoma. Alveolar giant-celled sarcoma. (The rare varieties observed by Billroth)	Known formerly as fungus hæmatodes, pulpy medullary sarcoma, fibroplastic tumours, and some cases of so-called encephaloid cancer.

(*e*) Carcinomas.
Anatomical varieties, now classed by Billroth, as—

(1) Acinous cancer. (2) Tubular cancer. (3) Shrinking cancer.	Variously known as scirrhus and medullary, or encephaloid cancer.
(4) Gelatinous cancer.	Colloid cancer.

As to the causes of tumours proper, many of them among the benign are known to be either congenital or developmental excrescences, as for instance—1. Dermoid and other congenital cysts in the permanent or temporary orifices, or in the cavities and organs of the body. 2. Pedunculated cartilaginous exostosis. 3. All nævi, warty and pigmented cutaneous moles. But a notion has arisen, and has been treated of by Cohnheim, that tumours have their origin in portions of embryonic tissue lying in the numerous interstices of the body, and undergoing the developmental alterations necessary to produce them; a form of growth which, in the case of simple solid tumours, is a mere repetition of that which occurred in the completed tissues which they imitate or exactly resemble. This notion has been so far supported by experiment that fragments of embryonic cartilage, transplanted to the aqueous chamber of the eye, to the peritoneal cavity, and into the stream in the jugular vein, have grown into cartilaginous tumours, whereas fragments of completed periosteum and hyaline cartilage, similarly dealt with, grew only for a time, and eventually underwent absorption. The notion, though quite as yet unproved, is interesting, if not important, affording a credible and comprehensible mode of accounting not only for all solid and some cystic benign tumours, but possibly malignant too, for, when considered along with a supposed anatomical alliance with inflammation of a possibly infective type, and with the strongly suspected "traumatic" excitation of "malignancy," one or other, and sometimes all, of these hypothetical explanations may be applicable to the origin of the groups sarcoma and carcinoma in completion of the idea. In fact, evidence is not wanting in support of some such idea in the case of certain instances of "branchial carcinoma" related by Volkmann (*Centralblatt f. Chir.*, Jan. 28th, 1882). This term he has applied to examples of deep, primary carcinoma of a distinctly cutaneous epithelial composition, excised by him from the stylo-hyoid region, and supposed to have arisen in epidermic structures included at the obliteration of the branchial clefts.[1] Among the tumours of the breast preserved in this museum is one (F. 30) of cystic nature, excised with the whole gland. The soft contents had the naked-eye appearance which characterises some softened epitheliomatous swellings, especially when secondarily affecting lymph glands, and the cyst wall was found by Mr. Paul to show the microscopic structure of unmistakable cutaneous epithelioma, an opinion which I entirely confirm from inspection of the slides. Such a product is extremely uncommon if not as yet unique, and not accounted for on any plan that has yet been devised to explain the origin of tumours, except the one now referred to. One may imagine a congenital or developmental aberration of cutaneous tissue, such as might form a small subcutaneous or even intra-mammary "dermoid cyst," however minute, subsequently undergoing the same transformation into epithelioma that any previously healthy cutaneous part would have to undergo when invaded by this disease. The same may apply to sarcomas, and may account for their hitherto mysterious appearance in the numerous connective tissues and interstitial spaces of the body. Their relation to congenital structures is so far known that a cutaneous pigmented mole may in after life be the actual and only seat of sarcomatous infiltration. Such a specimen is mounted in this museum. It is said that, under circumstances such as these, the usual malignant course is not manifested, though the structure be identical with that seldom unattended otherwise by recurrence, infection, and fatality.

[1] I have also met with one case of this kind, and have the microscopic slides prepared from a deep primary cutaneous epithelioma, removed some years ago from the left side of a middle-aged man's neck by Mr. J. P. Harris, assisted by me. The thing had puzzled me until I saw Volkmann's paper.

THE GUILD OF ST. LUKE.—The annual chapter of this Church Guild for medical men and students was held on Tuesday evening, Oct. 17th, at the English Church Union Rooms, Wellington-street, Strand. The Provost, Dr. Alfred Meadows, presided, and after reviewing the work of the year past, announced his intention of resigning his office, to the unfeigned regret of all present. The Treasurer, Dr. Holman, read the report for the year. Mr. George Cowell was elected Provost, Dr. Meadows Vice-Provost. Dr. Holman was re-elected Treasurer, and the Rev. G. Greenwood, Warden. Mr. A. K. Willis, Gascony House, West-end lane, N.W., was elected Secretary. On Wednesday (St. Luke's day) there was a celebration by the Warden at St. Thomas's, Regent-street, at 8 A.M. Afterwards the members sat down to breakfast at the residence of Dr. Meadows. Festal evensong was sung the same day at St. Paul's Cathedral by a choir of the London Gregorian Choral Association.

Introductory Lecture

TO THE

COURSE OF SURGERY

IN THE

UNIVERSITY OF EDINBURGH.

Delivered Oct. 24th, 1882.

BY JOHN CHIENE, M.D. EDIN.,

PROFESSOR OF SURGERY.

THE Chair of Systematic Surgery in the University of Edinburgh is of comparatively recent foundation. The cause of this is not far to seek. For many years it was held conjointly with the Chair of Anatomy. As the range of anatomical science increased in scope and importance, and when in 1736 the foundation of the Royal Infirmary by the Royal College of Physicians brought more prominently forward the practical aspects of surgical teaching, it was evident that the double work was too great for any one man. The Royal College of Surgeons early recognised this necessity, and in the interests of surgical science they petitioned the patrons in 1777 to found a separate chair. It was not, however, till the year 1831 that a Chair of Surgery was founded, and J. W. Turner was elected professor of surgery. He was succeeded in 1836 by the great physiologist and scientific surgeon, Charles Bell. He, in his turn, was succeeded in 1842 by James Miller; and on his death in 1864, James Spence, whose loss we now mourn, became professor of surgery. I well remember Mr. Spence's introductory lecture, delivered in this class-room eighteen years ago, before a crowded audience of students, former pupils, and friends: his leading thought—the gradual growth of surgical science; his subject—the Edinburgh School of Surgery. He laid special stress on the influence of John Bell and Robert Liston. Of John Bell he says, "He was no ordinary man, but a real surgical genius, of great natural talents, and imbued with that enthusiasm which is a mark of genius, and which does so much to create enthusiasm in others." Of Liston he says, "As a bold, and cool, and dexterous operator, I have scarcely seen his equal. His great power in diagnosis, the wonderful faculty he possessed of perceiving, as if by intuition, the true nature of a case in all its bearings, and of adopting adequate measures for its treatment was such as are rarely to be met with." Syme and Fergusson were then alive, and the time had not yet come to form an estimate of their great power for good. William Fergusson had gone to London, and was at that time at the height of his fame as a skilful surgeon, a brilliant operator, and, above all, a kind friend and adviser to anyone from Scotland. Of this I have a very pleasant recollection, when, in 1867, he gave me sound advice in what was probably the turning point of my career, advising me to stay in Edinburgh, and not to migrate south as so many of my countrymen had done. He never forgot the land of his birth. James Syme was then the leader of Scottish surgery, of whom it might truly be said in the words of that good kindly man, the author of "Rab and his Friends," "He was, I believe, the greatest surgeon Scotland ever produced." "He had that quality of primary minds of attaching permanently those he had relation to, his students never ceased to love him, and returned to him from all regions of the world." As one of his pupils may I be permitted, in John Brown's words, to say, "Of what he was to me—his patience, his affection, his trust, his wisdom, and still more, what he might have been to me had I made the most of him,—it is not for me now to speak. He remains in my mind as one of the strongest, clearest, capablest, most valuable understandings; one of the warmest, truest hearts I have had the privilege and the responsibility of knowing." It has often been a matter of surprise to me that Syme's works have never been re-issued in a collected form. They will always be classical. I feel sure of this that there are many of his old pupils who would gladly undertake the task. Mr. Spence, in his introductory lecture, pointed out to us, his students, the great importance of anatomy and clinical study, of the dissecting-room and the hospital ward. He could speak with authority on these points, because he had been for many years a teacher of anatomy, and for fifteen years a surgeon in the hospital and lecturer on surgery in the extra-mural school. When we remember that Charles Bell held the Chair of Surgery in this university, physiology must always play an important part in the surgical teaching. With our vivid recollection of the complete mastery James Spence had over all the details of anatomy, we can never forget the paramount importance of anatomical dissection as the basis of surgical practice.

As many of you know, it has been my endeavour, during the last twelve years, to teach the principles of surgery from a physiological standpoint, the practice of surgery from an anatomical point of view. While I certainly shall have difficulties as to the best way fully to utilise and develop the great opportunities for good which my present position affords, one thing I feel sure of is this, that in the future there will be no necessity for any departure from the method of teaching that I have always hitherto followed. I shall be encouraged, in so doing, by the remembrance that I hold a position previously occupied by Charles Bell and James Spence. It was my good fortune to be the pupil both of James Miller and James Spence. Miller, an eloquent lecturer, a brilliant operator, and a kind-hearted man; Spence, the representative, for some years before his death, of Scottish surgery, the careful and painstaking surgeon, whose skill as a diagnostic surgeon was unrivalled. You know how well he did his work as your professor; he never forgot—what has ever seemed to me the reason why Edinburgh attracts so many students,—that teaching was his primary duty. His daily lecture, his hospital visit, were to him a time sacred to learning and teaching, and not to be lightly interfered with by the calls of practice, however urgent. You know how hard he worked; of late the troubles of declining years interfering in no way with that thoroughness in all he did, and that daily round of arduous duties, the performance of which was to him his chief pleasure and his life-work. I would desire to remind you of his avoidance of all show. I recall at the present moment the early days of the winter session of 1862, the operating theatre in the Old Infirmary, Spence evidently pre-occupied, restless, and excusing his restlessness by an occasional glance at the instrument-tray, as if every knife and every needle had not been carefully examined and arranged by himself; the theatre crowded to the ceiling, a small sprinkling of practitioners amongst a host of students. The juniors, of whom I was one, were somewhat anxious, and perhaps not over-confident of their staying powers; the seniors, who had left the medical house to visit their old haunts and see "Spence operate," were there in great force, some perhaps thinking of the time when they were juniors, with heart-searchings of time misspent, never to be recalled, others in whispered comments recalling some dreadful operation which they had witnessed, patronising, but withal in a kindly fatherly manner, us juniors. The patient was soon brought in, a pale but healthy middle-aged woman. She suffered from a large tumour of the neck. I need not detain you with an account of the operation; the time seemed to me short—it must have occupied an hour. During all that time Spence went on with his work quietly; little was said, but gradually the large growth, separated from its attachments, became more and more apparent, until at last it was removed, and a gap was left, exposing the carotid vessels and the internal jugular vein from the angle of the jaw to the clavicle. That large blue vein is still vividly before me. I remember my only thought was, that man must be a good anatomist. This was my first lesson from James Spence; since that day it has been my great privilege to receive from him very many practical lessons and much kindness. It will be an evil day for the teaching of surgery in this school when the useful lessons which Spence taught are forgotten by his pupils. He was a good practical surgeon, a kind friend, and an honest man. In his "Lectures on Surgery" he has left us a guide which will always be eminently trustworthy, more especially in those branches of practical surgery to which he devoted special attention. His chapters on hernia, aneurism, diphtheria, croup, stone in the bladder, their diagnosis and treatment, are to my mind full of sound advice, and will always be read and acted upon, and Spence's name will be handed down as an authority in practical surgery.

The term "introductory" may refer either to the lecturer or to his subject. Personally I am pleased to feel that I require no formal introduction. May I then be permitted to

utilise what remains of this hour, and make it a part of the course on which we are now entering? I have no desire that this lecture should in any sense be of the nature of a pastime, but that to-day, as I trust in every lecture this session, something will be learned by you and by me. To be useful, what I have to say must be more or less elementary; for this I cannot but feel that I owe an apology to those present, old friends and former pupils, who come here to welcome me in a new position, and to other kindly critics present, who have perhaps finished or are now finishing their university course. While my remarks are more especially addressed to students of the second year who are commencing the study of surgery, I am well aware that there are some present fresh from school life who are only now beginning their medical studies, and who as yet consider it a privilege to attend an introductory lecture, and who can still enjoy their comparative freedom as university students, comparing it favourably with the rigour of school discipline with which very lately they were so well acquainted. May I as a friend say to them a passing word? In your present freedom there is a great danger: see that you use that freedom aright. Remember that you are now university men. Your school looks to you to be a credit to your up-bringing; your university hopes in the future to be proud of you. Take this to heart, that your future prosperity very much depends on the way you spend your *first* year here. I earnestly entreat you to take great care what friends you now make. You will most certainly be tempted. Learn then, above all things, to be able to say "No;" that is the whole business, and I have no fear of the result. "Read carefully; do not be satisfied with a superficial understanding of a book, nor hastily give your assent to those who talk too much."

Pardon me for this short digression; I could not help it. I have seen in my day many bright beginnings end only in disaster, self-reproach, and home misery. My audience is a large one; perhaps what I have now said may be of use to some one junior student now present.

The healing of wounds has from the beginning occupied the attention of surgeons. Rapidity of healing and freedom from pain during the process have mainly been sought after in their treatment. In saying a few words regarding wounds, I would first direct your attention to the treatment of a wound twenty years ago, when I was a student, comparing it with its treatment at the present time. I necessarily, in my comparison, take the practice of the school with which I am most familiar. Its practice, however, has always been a pretty good gauge of the work of practical surgeons. I do not wish to say that it has been foremost, but certainly it has always been among the first to institute or to adopt any improvements. Twenty years ago, as at present, there were differences of opinion in minutiæ, but the practice of the majority at either period will be taken as the basis of our comparison. I will have no difficulty in showing that most remarkable alterations have taken place; and I will then ask you to look into the past history of surgery, and I think be able to show you that the present practice has been more than foreshadowed, and that much that is now done has been done long ago. In some minds there seems a tendency to dwell upon the so-called ignorance of our forefathers. I would assert the very opposite, and say that there were clear-headed, shrewd, and intelligent surgeons in those days who can most favourably be compared with the present generation. This assertion, if just, is a comforting one, and may encourage us to hope that any honest, truthful work that is now being done will be appreciated by our successors. If then I can show that the present practice of surgery is a revival of what was done in the past, it will be my endeavour in the next place to point out the real difference, and to show that, while surgeons formerly worked empirically, we are now working on a scientific basis.

The present practice and its results on general surgery will occupy our attention during the coming session. While I have no desire to prophesy concerning its influence in the future, or to predict its permanency, I would suggest, that if I can show that the whole history of practical surgery has been more or less an empirical struggle to overcome difficulties and dangers, the primary cause of which is now clearly understood, then this fact encourages the belief that the present change, in so far as it is founded on a scientific basis, will be a permanent one. The practical details will most certainly change—are in fact daily changing—and will be improved while the great primary truth on which it is founded will always be our standard. There is a great law governing our physical and mental well-being—namely, that growth and development are accompanied by change, that to stand still and make no advance must necessarily soon be followed by physical and mental decay. Twenty years ago in the treatment of any large recent incised wound, the bleeding arteries were tied with well-waxed silk ligatures. The ligatures were left long and brought out at the corners, or at the most dependent part of the wound. Plenty of cold water was used to wash the wound; the edges were brought together with silver stitches, and a piece of dry lint was laid over the incision and retained in position by a bandage. As a rule this dressing was not touched till the second or third day, when it was removed in consequence of local uneasiness. This removal was always accompanied by a certain amount of pain, which was modified by soaking the lint with warm water before removal. Occasionally, in consequence of the absence of uneasiness, the lint was untouched for a longer period, and removed at the end of a week or ten days to find that union by the first intention had taken place, except at the point or points where the silk ligatures emerged. Sooner or later these ligatures became loose and were removed one by one, when complete healing occurred. The uneasiness complained of was due to local tension as evidenced by redness of the lips of the wound. This redness and uneasiness were relieved by bathing with warm water, or by the application of warm-water dressing (lint and gutta-percha), or by the removal of a stitch or stitches, when the confined discharge escaped as pus. If this pus had a disagreeable odour, then the cavity of the wound was gently washed out with a syringe filled either with simple warm water, or with warm water tinged with Condy's fluid. The wound was dressed night and morning, sometimes even more frequently, and gradual consolidation by means of union by the second intention took place. I make no allusion to the constitutional dangers of which every now and then sad examples occurred, sometimes sporadic, sometimes epidemic, except to say that the principal danger, termed pyæmia, was looked upon as in great part due to the constitution of the patients. The treatment of this danger was entirely curative—quinine, iron, and stimulants were freely administered. Prophylaxis did not occupy the practical mind, because the primary cause of the condition was unknown. Nowadays the treatment of a recent incised wound, as most of you know, is very different. The vessels are tied with catgut instead of silk, the ends of the ligatures are cut short, and we see no more of them. The wound is thoroughly washed with an antiseptic lotion, and a drainage-tube, a hank of catgut or of horsehair, is introduced to the bottom of the wound and brought out at a dependent point. The wound is stitched and a dressing is applied, the essential feature of which is that it contains some antiseptic. This dressing is not interfered with until the discharge soaks through it, or appears at its edges, or unless the wound is painful. This pain is due to an imperfect application of the drainage. The wound is never exposed to the air, but is examined under cover of a cloud of antiseptic vapour. The wound, as a rule, heals without suppuration and without pain.

Here, then, we have two very different pictures: the main differences between them seem to be, ligatures of catgut instead of silk, free drainage, and antiseptic precautions. Are any of these methods really new? Physic of New York, Astley Cooper, and others, used catgut; John Vigo and Ambrose Paré recommended drainage-tubes; Würtz alludes to drainage by means of a hank of horsehair; Guy de Chauliac, Vigo, Arcæus, Würtz, Purmannus, Ambrose Paré, Colbatch, and others used various antiseptics—turpentine, alcohol, camphor, myrrh, and various resins. External dressings were applied containing antiseptics. Watson Cheyne, in his recent valuable work on "Antiseptic Surgery," speaks of Arcæus's treatment as "a fair antiseptic method, and not far removed from an aseptic one." These surgeons whom I have named flourished between 1350 and 1750. During these centuries we find, in the great majority of the surgical works, that much stress is laid upon putrefaction. We find, for example, that Guy de Chauliac, Vigo, and Woodall, define a wound as a solution of continuity—fresh, bloody, and free from putrefaction; and they speak of their remedies as of use in preventing and curing putrefaction. Not only do they mention putrefaction as an evil thing, but we find that Paré, Würtz, Magatus, Colbatch, Belloste, Heister, Benjamin Bell, Alexander Munro, and Abernethy, all considered that the entrance of air into the wound is in some unknown way associated with inflammation

and unsatisfactory healing; while Paré and Magatus, in the beginning of the sixteenth century, tell us that the air is charged with miasms, and warn us to avoid such air. In consequence more especially of the teaching of John Hunter and John Bell towards the end of the last and the beginning of this century, these views with regard to the evil effects of the air were almost lost sight of. In consequence, more especially of the teaching of Syme and Liston, simplicity of dressing, such as I have described as made use of in 1860, was the rule in surgical practice. At the same time it is to be noted that the valvular openings recommended by Abernethy, the aspirator long ago recommended by Delarroix and Anel, and subcutaneous surgery generally, retained their place in the practice of surgery. In the beginning of the present century chemists, scientific men, having no knowledge of, and altogether apart from, the practice of surgery, began the study of fermentation, described the products of the process, and searched after the cause. Schwann demonstrated that the oxygen in the air was not the cause, and in 1836 he and Cagniard de Latour discovered independently the yeast plant, and its constant association with alcoholic fermentation. After a time this plant was shown to be the cause of the alcoholic fermentation. Pasteur, in 1858, made the next great step, and pointed out that putrescence is a form of fermentation, and brought forward the doctrine that this is due to organisms planted in a putrescible substance. This doctrine has, up to the present day, been termed the germ theory of putrefaction. This theory is now proved to be correct, and as we speak of Newton's Law of Gravitation, so I am of opinion that we are now in a position to speak of Pasteur's Law of Fermentation. All this work, it will be observed, was done by scientific men, apart from and apparently unconnected with the practice of surgery. For some years before 1860 there were various indications that this scientific work was soon to be utilised in surgical practice, and there can be no doubt that to Lemaire the credit is due of having first *seen* the connexion. He used coal tar and carbolic acid as disinfectants in wounds. It is unnecessary to inquire the reason why the work of Lemaire did not gain general acceptance. The fact undoubtedly exists, that his ideas were not adopted by the majority, and that they were even abandoned by those surgeons who had given them a trial.

(*To be concluded.*)

RUPTURE OF THE URINARY BLADDER.[1]

BY WALTER RIVINGTON, F.R.C.S. ENG.,
SURGEON TO THE LONDON HOSPITAL.

PART II.

SYMPTOMS AND DIAGNOSIS.

THE primary symptoms of rupture of the urinary bladder will be more or less marked according to the condition of the patient at the time of the occurrence. If the sufferer, as is too frequently the case, happens to be intoxicated, he may be unconscious of anything amiss. He may be found lying insensible on the highway, or be picked up in the street as simply inebriate, and be carried to a police station or to the hospital, or walk into an adjoining room and go to bed, or stagger to his home, and only become alive the next morning to the fact that he has sustained a grave injury. If the accident occurs to a sober individual, or to one who is only convivial or slightly tipsy, there will be, at the moment of rupture, intense pain at the umbilicus or in the hypogastrium, or perhaps faintness or complete syncope, and a feeling of something having given way within the abdomen. The sensation of something having given way is common to the traumatic and idiopathic cases. In the majority of instances of intra-peritoneal rupture the power of locomotion is either abolished or very greatly impaired, and, even if the sufferer be able to walk, he will in all probability do so slowly, painfully, in a stooping position, or with the assistance of others. In five cases the power of locomotion seems to have been retained in a more remarkable degree (cases related by Dr. Alfred Taylor,[2] Mr. Hird,[3] Dr. Harrison,[4] Mr. Crossley,[5] and Dr. Gillespie[6]). In Dr. Harrison's case the patient kept about and at work till the fourth day after the injury. At the post-mortem the recto-vesical cul-de-sac was seen to be shut off from the general cavity of the peritoneum by adhesions between the lower intestines and the bladder, and contained a quart of colourless urine. It has been conjectured that the retention of the urine in the cul-de-sac would not be attended with the same immediate disturbance to the system as its diffusion through the general peritoneal cavity. This explanation, though possible, does not appear to me to be so probable as the occurrence at first of a partial rupture afterwards becoming complete. Dr. Max Bartels alludes to the latter method of explanation, and appears to lean towards it.

As soon as the shock, pain, and peculiar feelings occasioned by a ruptured bladder have subsided, the subject of the injury, who had previously felt an urgent call to void urine, and may have been on his way to satisfy the call, experiences, perhaps, a temporary feeling of relief. Very soon, however, he begins to be tormented with a strong and frequent desire to make water. On attempting to do so nothing comes away, but straining may cause a few drops of blood, or bloody urine, to issue from the urethra. Accompanying this distressing condition pain will be felt in the hypogastric region, or there may be constant acute pain at the umbilicus or all over the belly, the pain being intolerable in the erect position. Pallor and anxiety of countenance, restlessness, thirst, difficulty in movement, nausea and vomiting, depression, and feeble pulse will be the evidences of grave constitutional disturbances. The introduction of the catheter draws off blood, or a variable quantity of blood and urine combined, or fails to remove anything at all. Usually the catheter will pass readily enough into the empty and more or less contracted or collapsed bladder. When the point of the catheter impinges on a sound part of the wall it will be found difficult to rotate the instrument and to depress it between the patient's thighs, but if the rent is in the posterior wall, on withdrawing the catheter a little and altering its direction it may suddenly slip through the rent into the peritoneal cavity, become freely movable, and withdraw a large or considerable quantity of fluid. The amount of blood mixed with the urine is variable. The quantity of urine drawn on occasions subsequent to the first introduction will vary according to the frequency of catheterism and the position of the extremity of the instrument. A catheter confined to the cavity of a ruptured bladder will not remove more than a few ounces of urine, rarely, I think, more than four or six at the most, but whenever it traverses the rent half a pint to thirty ounces and even more fluid may be expected to issue. As the contraction of the muscular coat of the bladder no longer assists the flow, and as the abdominal muscles will probably be exerted only for the purposes of respiration, the urine will either well out gradually and run down by the side of the catheter, come out almost *guttatim*, or pass from the instrument in an intermittent stream during the periods of expiration. As a general rule the patient from the first is unable to pass water, and continues to display this inability to the end. In a few cases water has been passed voluntarily by the patient, either at the outset or at some period during the progress of the case. In my fourth case, where the rupture was situated just above the prostate, there was at first incontinence of urine, and in a recent case of idiopathic rupture behind the prostate, brought before the Hunterian Society by Mr. Tay, urine seems to have dribbled rather freely from the urethra.

The primary symptoms which have been enumerated, pain in the abdomen, a feeling of something having given way within that cavity, difficulty in standing and walking, a certain amount of shock or depression, temporary relief to the desire to make water, followed by a more urgent desire but inability to do so, and the results of catheterism in bringing away blood or bloody urine, or nothing whatever, are common both to the intra- and extra-peritoneal ruptures. Here, however, the two classes of cases diverge from each other. In the intra-peritoneal ruptures the symptoms are decidedly more severe. The shock at first is greater, and the symptoms of peritonitis, as a rule, set in within a few hours and increase in severity. Only in a severe injury is

[1] The particulars of the reported cases of recovery and illustrations of the statements made in the text are omitted in this abstract, which nearly corresponds to a paper read at the Hunterian Society on Oct. 11th, 1882.

[2] Medical Jurisprudence. [3] THE LANCET, Oct. 3rd, 1846. [4] Op. cit.
[5] Med. Times and Gazette, 1872. [6] Ed. Med. Journal, 1859, p. 811.

any external mark of violence likely to be observed. Most probably the abdomen will be found swollen or prominent in front, tender on the slightest pressure, and tympanitic, but in the hypogastric region for a variable distance, and sometimes extending towards one or both iliac fossæ, the percussion note is likely to be dull, more especially in the erect position. There may even be a more or less defined swelling resembling the bladder between the umbilicus and pubes, due to the circumstance that the urine is temporarily confined by the disposition of the coils of intestine. Examination per rectum will elicit tenderness and pain, and in some cases the fingers may be able to detect a collection of fluid in the recto-vesical cul-de-sac. As a general rule there is no collection of fluid in this situation. In a typical case of intra-peritoneal rupture the patient will exhibit all the symptoms of peritonitis in addition to those proper to the lesion itself. He will lie in bed with his knees drawn up, or be propped up with pillows to relax the abdominal muscles. He will have a pinched, anxious, haggard expression of countenance, look pale and anæmic, and be tormented with a frequent or constant desire to make water leading to ineffectual efforts to empty the bladder. He will suffer from thirst, and sooner or later be troubled with vomiting, bringing up a greenish-yellow fluid, and even the water which he had drunk copiously to quench his thirst. With vomiting hiccough is frequently associated. The pulse will be small, feeble, and rapid, ranging between 90 and 130. The temperature will probably be a little over the normal. The respirations will be hurried, accompanied, perhaps, by dyspnœa, or a feeling of oppression at the chest. The abdomen will be tense, tender, tympanitic above, dull and possibly fluctuating below. The tongue will be furred and dry, and the bowels confined. Occasionally there may be rolling of the intestines and distressing tenesmus. Unless stupefied with alcohol, the patient may be expected to pass the first night after the injury in much torture, vainly endeavouring to procure rest and sleep. Throughout the illness there will be marked restlessness and insomnia. As the case proceeds the symptoms become aggravated; the swelling and tension of the abdomen increase; clammy sweats appear on the skin; the hiccough and vomiting become more urgent and distressing; the pain is intolerable; the countenance sunken and ghastly, and the patient may sink into a state of collapse, or a typhoid condition attended with delirium and coma. Not infrequently, after a few days, especially about the fifth or sixth, if the patient survive so long, there are marked signs of amendment. Nature has commenced the repair of the rent in the bladder, and the edges of the rent have become agglutinated or blocked by the sigmoid flexure or a coil of small intestine. The patient passes water voluntarily, takes food without rejecting it, sits up in bed, is free from pain and comparatively cheerful. An error in diet, or a purgative acting on the bowel, or the course of the disease itself, dispels the deceitful improvement, the former symptoms recur, and the patient may expire on the very day which follows the signs of hopefulness and recovery. In one or two cases stercoraceous vomiting has occurred, and in a case at St. Bartholomew's Hospital a coil of intestine entered the rent in the bladder, and gave rise to symptoms of intestinal obstruction which masked the symptoms of rupture of the bladder. In the extra-peritoneal ruptures the symptoms of peritonitis will not be present, unless the peritoneum has been injured by the violence which occasioned the rupture of the bladder, or becomes involved secondarily, either by contact with urine effused under it, or in the course of the diffuse inflammation and sloughing of the sub-peritoneal areolar tissue. In regard to the local symptoms, a less amount of urine may be expected to follow the introduction of the catheter than in the intra-peritoneal ruptures, as the point of the catheter will not readily enter the rent in the bladder. Nevertheless, manipulation with the finger in the rectum may occasionally succeed in causing the point of the catheter to pass through the rent into a pouch outside the bladder, containing urine mixed with blood and the products of inflammation. The situation of the collection will vary according to the position of the opening in the bladder. When the rent is in front, the urine either forms a circumscribed tumour outside and anteriorly to the bladder, occasioning marked dulness on percussion, or it becomes widely diffused, mounting up towards the umbilicus between the peritoneum and the abdominal muscles, or passing into the iliac fossæ, or through the obturator foramina, and the inguinal and femoral canals into the thigh and scrotum. When the opening is behind the prostate the fluid will ascend into one or other of the iliac fossæ. Wherever extravasation occurs it sets up inflammation in the connective tissue and fasciæ, followed in due time by suppuration and sloughing. Occasionally the urine is collected in a kind of sacculus, the walls of which are composed of connective tissue matted by lymph, simulating the appearance of a lining membrane to the adventitious cavity. The general symptoms will be less marked than in the intra-peritoneal ruptures, and be of the character familiar to the surgeon in connexion with extravasation of urine.

In a typical case the diagnosis will be easy, but it is likely to be obscure if the surgeon cannot obtain a satisfactory history of the case, or where the symptoms are masked or slight, and in which, possibly, the patient has passed water voluntarily, or when it flows from the urethra. The surgeon needs to be constantly on the alert, and to have his mind directed to the possibility of rupture not only where there has been an abdominal injury, but in cases of retention from stricture, or from hypertrophy of the prostate gland, or from any other cause, and where the patient comes under his care stupefied with alcohol. In extra-peritoneal ruptures doubt will soon be removed by the occurrence of extravasation of urine, but in the intra-peritoneal I believe that the best local test is the possibility of passing the point of a long catheter through the rent into the peritoneal cavity, allowing free movement and drawing off a large quantity of fluid. When contrasted with a prior limitation of rotation, and of depression, and the removal of blood, or a very small quantity of bloody urine after the instrument had undoubtedly passed the prostate gland, the sudden slipping of the catheter up to the hilt in the urethra, with the effect stated, is extremely significant. Mr. Heath injected warm water through the catheter, and the stream was distinctly felt by the patient in the groins and abdomen. This means of diagnosis might be used when the surgeon could not make one without it, but it tends to diffuse the urine already present in the peritoneal cavity, and it is probable that the warm water itself may exercise an injurious effect upon the peritoneum. If the bladder is sound, injection of fluid ought to furnish decisive evidence by causing the formation of a circumscribed tumour, which disappears on catheterism with recovery of the fluid.

One great disadvantage of an incorrect diagnosis and mistaking some other form of abdominal injury for a ruptured bladder, or an extra-peritoneal for an intra-peritoneal rent, is that if recovery ensues the case is published with a flourish, and the treatment pursued is quoted as well worthy of adoption in a similar case. In recent years there has been a serious increase in the number of reported cases of recovery after an alleged rupture of the bladder, and several are said to have been ruptures into the peritoneal cavity. Before accepting any case as a genuine instance of recovery after simple uncomplicated intra-peritoneal rupture, the following points should be well considered:—

1. It is desirable to have clear evidence that the bladder was full at the time of the accident. A distended bladder can scarcely escape from a severe blow or contusion of the abdomen, but a bladder empty, or nearly so, and under the protection of the pelvic bones, may elude the greatest violence.

2. It must be borne in mind that the bladder may be merely contused or displaced, and that many of the symptoms of rupture may be present—viz., blood in the urine, inability to micturate with desire to do so, and some difficulty in the passage of the catheter. A case of this kind I have seen, and Mr. Le Gros Clark's case, which has been quoted as an example of rupture, certainly appears to me to be an instance in point. In the history of the case no evidence is adduced to show that the bladder was distended at the time of the accident; the most typical primary symptoms, a feeling of something having given way, a distressing desire with inability to micturate, and the peculiar results obtainable by manipulation after passage of the catheter, were absent, and the quantity of urine removed or passed does not appear to have been at any time defective.

3. Difficulty experienced in drawing off a patient's water, and the necessity for altering the direction of the catheter or the position of the patient before succeeding, cannot be taken as conclusive evidence of a rupture of the bladder. A blocked catheter, hitching in a fold of mucous membrane, a swollen veru montanum, entrance of the point of the catheter into the sinus pocularis or a false passage, displace-

ment of the bladder, submucous extravasation of blood, and enlargement of the prostate gland, may all occasion impediments.

4. It is erroneous to suppose that the peritoneum tolerates the presence of pent-up urine. The idea of tolerance appears to have originated partly from the fact that post-mortem examinations of cases of ruptured bladder sometimes detect very slight, if any, traces of peritonitis, and partly on cases which appear to indicate the ability of the peritoneum to absorb effused urine. The basis will not support the superstructure. For if the history and progress of the cases in which pathological peritonitis was absent be examined, all the symptoms of intense irritation and inflammation of the peritoneum will be found, and the issue was death. The presence of absence of lymph, as evidence of inflammation and irritation or the contrary, is little to the purpose. Purulent collections or serous exudation may take the place of lymph, and evidently the tolerance of urine by the peritoneum must be judged not merely by the effusion of lymph, but by the local and general symptoms and by the issue of the case. If the intrusion of urine into the peritoneal cavity produces intense pain, tenderness, and distension of the abdomen, and if these symptoms are accompanied by constant vomiting, restlessness, a sunken anxious countenance, altered temperature, feeble pulse, hurried respiration, clammy sweats and intense prostration, terminating in death, I cannot understand why it should be affirmed that the peritoneum tolerates the presence of pent-up urine because after death it is sometimes found to have retained its smooth glistening aspect, and to be free from undue vascularity, adhesions, and lymph. That the peritoneum may absorb urine effused into its cavity I will not dispute, though I believe that this absorption is slight. But even if it takes place in any quantity, as conjectured by Solly, Le Gros Clark, Max Bartels and others, I entertain no doubt whatever that it exercises a most depressing influence upon the system of the patient, so that the matter may be summed up in this way: However tolerant of urine the peritoneum may appear in some cases of ruptured bladder, intolerance of it is plainly exhibited by the system of the patient. Nor is urine tolerated in the areolar tissue, be it the urine of the infant or the urine of the adult. Both alike, when pent-up in the meshes of the tissue, will set up inflammation, suppuration and sloughing, and I distrust altogether any statements which would involve any opposite conclusion.

A SCHEME FOR THE MORE COMPREHENSIVE STUDY AND PREVENTION OF SO-CALLED ZYMOTIC DISEASES.

BY THOMAS M. DOLAN, F.R.C.S. EDIN.

PROVISIONAL OUTLINE.

THE theory of creative evolution has placed the study of the genesis of species on a scientific basis. The germ theory promises as much for medicine. A richer fruition will result if the germ theory be studied by the light of evolution. We have seen its application in the animal and vegetable world; it has been extended to the sociological aspects of life, &c. It may be applied with advantage to the study of disease. Disease is not an entity standing alone. It should always be considered in its relation to the cosmos. Buckle, in his "History of Civilisation," vol. iii., p. 447, tells us that the great glory of Hunter as a pathologist was that he formed the grand conception of a universal pathology. Buckle says: "With him [Hunter] the science of pathology did not mean the laws of disease in man alone, or even in all animals, or even in the whole organic kingdom; but it meant the laws of disease and of malformation in the entire material world, organic and inorganic. His great object was to raise a science of the abnormal. He determined to contemplate nature as a vast and complicated whole, exhibiting indeed at different times different appearances, but preserving amidst every change a principle of uniform and uninterrupted order, admitting of no deviation, undergoing no disturbance, and presenting no real irregularity." In the views herein set forth there is then nothing new, except perhaps in the method in which they are set forth. It is one which has occurred to many minds. There is a tendency at the present time to consider disease in its relation to evolution. The papers by Dr. Airy, Dr. Roberts, Surgeon-General Gordon, and Mr. Millican indicate the direction in which this current is setting. The principal zymotic diseases are small-pox, scarlatina, measles, whooping-cough, diphtheria, cholera, and typhoid. We have evidence to support the view that these diseases are caused by micro-organisms. These diseases must be studied in the same way that the naturalist studies animals and plants. The naturalist, when engaged in the study of the life-history of any individual animal or plant, looks in a broad-world point of view at his subject, and by the aid of evolution throws light on the genesis, distribution, development, transmutation, and varieties of each animal and plant. The scientific physician must approach the study of disease in the same way.

The following is an outline of what I believe should be done:—

1. *The Genesis of Contagium Vivum.*—Under this head will be included the life-history of each form, tracing it as far back as possible. Evolution does not tell us when each seed, as, for instance, that of the oak or the ash, first appeared. We can only go as far back as the historical period extends; so we cannot expect to be able to reach the ultimate stage when each disease first appeared. Evolution fixes in what part of the globe each plant examined first appeared, as the scientist not only traces back to the earliest period its existence, but also, by the study of its habits, is able to determine the zone in which it could exist. As regards the genesis of each individual disease germ we must apply the general principles of evolution.

2. *Reproduction.*—Under this head will be considered the mode of reproduction, whether slow or rapid, whether the seeds are derived from seed forms, or whether multiplication takes place by fission. Example: Drs. Dallinger and Drysdale's experiments on the life-history of some monads. These observations are models of what is wanted.

3. *Development, Maturity, and Decay.*—Duration of life in each form of contagium. How long may it be preserved? Average period of existence in mature and embryonic form. Morphology and physiology.

4. *Laws Controlling Contagia, &c.*—Special seasons of activity; the influence of environment on each disease; sanitary conditions and relation to physical phenomena; influence of oxygen in the atmosphere; heredity, variations; crossing or transmutation; susceptibility; relation of the habitat; progressive development of types; application of analogy of laws regulating plant life.

5. *Distribution in its Geographical Relations.*—Influence of climate; atmospheric variations; warmth, moisture, winds, barometric, electric, thermic disturbance, &c. Secondary natural influences; currents; winds; animals, transport by. Effects of human interference. Example: Measles introduced into Fiji Islands. Migrations. Effects of cultivation by civilisation. Effects of extinction of diseases by sanitation, similar to extinction of weeds in the plant world. Distribution of disease in zones. Relation of disease to flora and fauna. Natural selection for localities. Latitudes in which diseases are found. General method of diffusion.

6. *Geological Distribution.*—Nature of soil, subsoil, alluvium, clay, &c.; rock. Mountain, valley, or plain; drainage; swamps; watershed; rivers; lakes.

GENERAL PREVENTIVE MEASURES.

These can only be secured by establishing, as it were, a sanitary cordon round the world, and by the combined investigation of disease by an international method,—London, Paris, Berlin, Vienna, Brussels, &c., to be in communication, so that the heads of sanitary bureaux in each country may know the sanitary state of each country. This could be done by maps, charts, and records, to be framed and kept on a uniform plan. The incidence of disease in individuals and communities will be noted; sex, age, colour, nationality will have their proper place assigned; sporadic, endemic, and epidemic states will be considered in relation to causation. Hygiene will thus be carried out in a cosmic spirit; all those minor considerations as trades and professions will be examined in their relation to disease; whilst the value of food, pure air, water, &c., will be also appraised.

Vast statistics on almost every point connected with disease will by these means be secured, and conclusions drawn

therefrom. Thus will be obtained the sum of the conditions of the causes and propagation of disease; thus will be found the varying effects of climate and other agencies; and, above all, we shall learn the value of preventive measures necessary for its eradication. We have not as yet in England arrived at an appreciation of some of the simplest elementary truths in reference to prevention; for instance, the notification of infectious diseases and hospital accommodation for them are two of the first essentials. They should be State regulations. Each town is now allowed local option as to what it shall do. It seems Quixotic to attempt a broader scheme in the face of the prevailing indifference or disregard for both these measures in England. Prevention and spread of disease are not only State questions, but they have a cosmopolitan interest. Now that communication between different countries is so rapid and so much facilitated by steam, the health of one country is of vital interest to all countries; causes operating in England may affect France and *vice versâ*. For example, let us take the sanitary state of Hull. Hull is a seaport town. Let us look at the sanitary state of this town in the year 1881. In consequence of the prevalence of scarlatina the Local Government Board sent down Dr. Airy to inquire into the sanitary condition of the town. Dr. Airy held the inquiry on the 9th and 10th of March. The medical profession of the town submitted a memorial from which I extract a few items. The memorial sets forth that the outfalls of the sewers are blocked for sixteen hours out of the twenty-four, and that the ventilation of the sewers is most defective. The present mode of collection of night soil is very inefficient, being effected irregularly in open carts. Refuse is deposited in various parts of the town on unused plots of ground. The connexion of houses with the main drainage is notoriously insufficient. New houses are not examined during the course of erection as to their drainage and other sanitary arrangements, and building sites are frequently formed by the filling up of disused brickponds with animal and vegetable refuse and street scrapings. The Artisans and Labourers' Dwellings Act and the Sale of Food and Drugs Act are not properly carried out, nor are the sections of the Public Health Act dealing with offensive trades and the smoke nuisance. A reservoir supplying water to the town is uncovered, though exposed to the foul emanations issuing from fish and bone manure works in close proximity. The hospital accommodation for cases of infectious disease occurring in the town is totally inadequate, especially in view of the special danger to Hull arising from its close and frequent communication with the Continent. Disinfection is not undertaken by the local authorities free of expense, and the charges which the Corporation make no doubt deter many people from having their disinfection properly done. There is no mortuary in the town, and the means adopted for the prevention of epidemics are generally inadequate. This is a sad picture in the nineteenth century. Hull in this insanitary condition is a danger to the world. She may distribute scarlatina by ships as well as wind and wave currents. At present health officers of different countries are ignorant of the general sanitary state of other countries. Under my system the state of Hull would be known. Perhaps a friendly communication might be made by some foreign State to the Minister of Public Health in England to look after the sanitary state of Hull if this international system were at work.

My leading ideas are—1. That the sanitary authorities of each country should work on one uniform plan and under central direction. 2. That all sanitary authorities in every country should interchange maps, &c., and that the methods of recording disease should be the same. It is easy to draw up forms for international use. I have given one quotation from Buckle. I shall conclude with another, as an excuse for not tracing in detail the way in which diseases have originated or spread:—"To do this would require a learning and a reach of thought to which hardly any single man ought to pretend, since it is one thing to have a perception of a large and general truth, and it is another thing to follow out the truth in all its ramifications, and prove it by such evidence as will satisfy ordinary readers"—(vol. i., p. 131).

Halifax.

THE committee of the Hastings Infirmary have just accepted an offer from the Misses Brisco to present to the trustees the large and commodious White Rock Villa for the purposes of a convalescent home for the infirmary patients.

SOME OBSERVATIONS ON THE CONTAGIOUS DISEASES ACTS.

BY RAWDON MACNAMARA, F.R.C.S.I.,
SENIOR SURGEON TO THE WESTMORELAND LOCK (GOVERNMENT) HOSPITAL, DUBLIN.

OF the many burning questions at present agitating our minds, perhaps there is none discussed with greater warmth than the propriety of retaining amongst our statutes the Acts of Parliament known by the name of the "Contagious Diseases Acts." Whether they should be abolished, retained, or even extended is discussed with an amount of energy approaching acrimony, calculated to excite surprise in the calm mind of a philosopher; and yet it strikes me that in all this controversy the question has been almost exclusively approached by those who would wish, not only their continuance, but their extension, from the man's side of the case, to a very great extent ignoring that of the woman; whilst the opponents of these measures seem to me to think that any beneficial results that may flow from such enactments are confined to the male sex—on their side also ignoring the woman in the discussion. Whilst at once avowing myself as an uncompromising opponent of the "billet de santé" system—an occupation in my opinion degrading to any respectable surgeon—still I should wish to point out, from the woman's standpoint of view, why it is that I should wish these Acts not only to be continued, but to be widely extended; and the facts which I shall submit in support of my views cannot be gainsaid—facts which, if called upon to do so, I can support by unquestionable documentary evidence. During the past five years our return of patients admitted into the Lock Hospital would show an average of 700 unfortunates annually admitted. Of these I am in a position to prove that 511 were reclaimed—something like one out of every seven saved from a life of sin!—225 sent to asylums, 88 reconciled and restored to their parents, 50 sent to the poor-houses, and 148 provided with respectable situations. All this good work due to the fact that their admission into the hospital brought them under the direct pious ministrations of our chaplains, the Rev. Dr. Gibson and the Very Rev. Canon Forde, whose exhortations, ably aided by our Matron, Mrs. Hogan, bore this good fruit. It would be but to abuse the patience of my readers were I to point out how inaccessible to such influences would have been these poor sinners were there no such hospital for their reception; and it is a matter for legitimate speculation how many more might have been rescued were the Acts compulsory, thereby bringing a larger number under such influences.

So far I have been considering the subject from its moral aspect. I should desire now to say a few words upon the physical side of the case. How often have I wished when admitting these unfortunates into my hospital that some of the most earnest of the opponents of the Contagious Diseases Acts could be present to judge for themselves the amount of suffering they would inflict upon an erring sister by permitting her to ply her trade at a period when to do so must have been present torture and future misery. How often has the question been as it were wrenched from me, "My poor girl, why have you not applied ere this?" No one in general practice and unconnected with a Lock hospital can have any idea of the fearful condition in which from time to time patients are admitted into my hospital, which is situated in a city unfortunately not under the Contagious Diseases Acts. Were these Acts in force in Dublin, it would be simply impossible for such harrowing cases to present themselves. As it is, patients rarely present themselves in the earlier stages of their disease, when their treatment is manifestly more amenable. The effect of this on our general population, and more especially upon our garrison, it is unnecessary for me to point out.

Dublin.

PRESENTATION.—Dr. Robert Jones, who has filled the office of Assistant Medical Officer at Earlswood Asylum for two years, and has just been appointed to a similar position at Colney Hatch Asylum, has been presented by the Earlswood staff with a very handsome timepiece and illuminated address as a mark of their high esteem and regard.

ON A CASE OF

PSORIASIS TREATED BY CHRYSOPHANIC ACID INTERNALLY.

BY LEWIS W. MARSHALL, M.D.,
SURGEON TO THE CHILDREN'S HOSPITAL, NOTTINGHAM.

THE following case is of interest in connexion with others published by Dr. Napier in THE LANCET of May 20th, because, while I endeavoured to act rigidly up to the rules laid down for the administration of chrysophanic acid internally by the author of the paper referred to, the result was not so favourable as could have been wished.

Sarah A. C——, aged thirteen years, was admitted to the Children's Hospital, Nottingham, on May 24th, 1882, having numbers of patches of psoriasis all over her trunk and upper and lower extremities, those on the legs being most numerous and the largest. They existed chiefly on the extensor surface of the arms and legs. She gave a history of having suffered from the rash for six months, when it appeared in small spots, gradually enlarging and becoming scaly. On the day of admission she was ordered the following diet and treatment:—One-third of a grain of chrysophanic acid, with a sufficient quantity of sugar of milk, three times a day, this powder to be used after a meal, and to be continued unless diarrhœa or vomiting ensued. Diet to consist of meat, and avoidance of farinaceous products.

May 25th: Vomited directly after powder last night (5 P.M.), when they were stopped, but resumed at 11 A.M. to-day.—26th: Vomited again last night; no pain or discomfort.—31st: Dose increased to half a grain three times daily; spots fading slightly.

June 5th: Dose increased to one grain.—9th: Vomited after the morning powder.—19th: Dose to be a grain and a quarter.—28th: Two-grain doses used; spots on hands less distinct; made out-patient, but to continue treatment.

July 1st: Spots improving, but not markedly so; has vomited twice since she left the hospital.—12th: States to-day that she vomits everything she eats, and the treatment was discontinued.—19th: An ointment of chrysophanic acid with vaseline (twenty grains to the ounce) was used locally, after which rapid improvement was noticed.

Sept. 8th: The patient was discharged well.—29th: To-day I have heard that the spots have not returned.

Nottingham.

A CASE OF COLIC FROM UNUSUAL CAUSE.

BY HERBERT FENTON, L.R.C.P., &c.

ON Saturday, Sept. 16th, I was called to see Mrs. H——, an Anglo-Indian lady whom I had attended in childbirth a month previously, and found her suffering from colicky pain of a particularly violent character, associated with distressing retching and vomiting.

The history the patient gave was that on the previous Thursday, whilst lifting a box, in weight about equal to a scuttle of coals, she felt a sudden sharp pain in the lower part of the stomach. No notice was taken of this at the time, and the usual household occupations were continued until Saturday evening, though not without occasional twinges of pain. Physical examination showed the abdomen dull on percussion in the left iliac region, though there was no definite tumour on palpation. Elsewhere the abdomen was slightly tympanitic. Tenderness was complained of, and the pain was greatly increased by pressure. There were no signs of hernia. The pulse was 60; temperature normal. Tongue coated with a soft creamy but thick white fur, and the bowels had been opened once since the first feeling of pain on the Thursday. An ordinary effervescing mixture, with two drops of prussic acid (Sch.) in each dose, was prescribed, and turpentine stupes directed to be applied over the abdomen. No food, except a little milk, to be given. On Sunday morning the symptoms, with the exception of the vomiting, which was slightly relieved, were aggravated. An ounce of castor oil, with forty minims of laudanum, was then given, and the bowels were relieved about eight o'clock the same evening. One of the neighbours who was acting as nurse kindly washed and examined the motion, and found a splinter of wood two inches in length and about as broad as three matches. At the time of passing the motion most agonising pain was experienced. After the passage of the wood the symptoms were all relieved, but what was described as a raw pain was still felt in the left iliac fossa. One grain of opium was then given every four hours, with a diet of milk and beef-tea. On the Monday there were signs of general peritonitis, which were speedily subdued by the free use of opium, and the patient then rapidly regained her usual health.

Remarks.—This case shows the necessity of carefully examining the motions in every case of intestinal obstruction, and also illustrates how the patient's own account may to a certain extent mislead; the pain experienced on lifting the box being perhaps a coincidence, perhaps due to some displacement of the previously innocuous piece of wood. The wood was probably swallowed with some French beans, which a boy who prepares them is accustomed to slice on the edge of the table, but at what time it was eaten is unknown.

Cumberland-street, S.W.

A Mirror
OF
HOSPITAL PRACTICE,
BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

MIDDLESEX HOSPITAL.

SURGICAL CASES.

(Under the care of Mr. A. CLARK.)

THE following cases which have lately been attending in the out-patient room present some features of interest.

CASE 1. *Chancre of Lower Lip, followed by Secondary Symptoms.* — E. B——, aged twenty-two, attended first on Dec. 29th, 1881, complaining of a hard swelling underneath her jaw. It did not take much consideration to decide that this was a glandular enlargement secondary to a sore on the lower lip, and the sore was a typical Hunterian chancre. The patient herself attached but little importance to the sore, which she stated she had had several weeks, but it was the hard increasing swelling which alarmed her. The girl's explanation of the lesion was that in the course of her employment, filling pickle-tins, she had accidentally cut her lip with a sharp edge. She declared she had kissed no one except a young man to whom she was expecting shortly to be married, and who was seen by Mr. Clark, and found to be perfectly healthy. The patient herself had always previously enjoyed good health, and there was no reason to believe that she had knowingly exposed herself to syphilitic infection; her own statement and that of her mother, who accompanied her, were perfectly straightforward. The treatment adopted was a drachm of the solution of perchloride of mercury three times a day, and in a week there was a marked improvement; in three weeks the chancre had all but healed, and the glandular enlargement much reduced, but then a rash appeared and ulcerated throat, and she has gone through the ordinary course of syphilis. Considering herself well on June 8th, when she discontinued her attendance of her own accord, only, however, to return with palmar psoriasis on July 8th, for which iodide of potassium was prescribed, and this she still continues to take.

CASE 2. *Abscess of the Parotid Gland.*—A. G——, aged fifty, first came on May 18th, 1882, with considerable enlargement about the right parotid, which she stated had been coming for several months. It was in the main hard, but there were several soft fluctuating nodules projecting from it; there was some enlargement of the submaxillary lymphatic glands and several carious teeth, but of these the patient did not complain. The diagnosis was between glandular abscess affecting the right parotid and enchondroma of the parotid. A mixture of carbonate of ammonia and chinchona was ordered, and locally an ointment of belladonna and iodide of potassium was applied. For the next two or three weeks the swelling continued to get harder

and larger, and it was not until Aug. 31st that it burst, and then it rapidly disappeared, leaving a small discharging sinus. The patient always declined to have anything done to her teeth.

CASE 3. *Enlarged Glands surrounding the Carotid Artery and simulating Aneurism.*—E. B——, aged thirty-three, presented herself on June 26th complaining of pain in the left side of her neck, the result of a blow there ten days previously. There was evident enlargement on that side and some induration round the carotid artery, and with each beat of the heart the tumour expanded in every direction; there was no redness of the skin, not much tenderness on ordinary manipulation, and no perceptible difference in the two radial pulses. There was some enlargement of the cervical glands; the diagnosis was between aneurismal dilatation of the carotid and glandular abscess. The former seemed the more likely. A local application of belladonna and iodide of potassium was ordered and a tonic given internally. She was seen again on June 29th, when there was no perceptible difference. On July 6th the objective signs were the same, but the patient complained of more pain, inability to sleep, and an unpleasant pulsation; she was therefore admitted as an in-patient, and a subsequent exploratory incision proved the case to be one of enlarged glands entirely surrounding the artery.

CASE 4. *Deep-seated Abscess in Axilla.*—L. C——, aged fifty-six, presented herself on April 10th, complaining of intense pain in her right axilla. She attributed it to a twist some three weeks previously, following which the pain began, and had expected it would get better of itself, but it daily increased in severity, and her health was beginning to be affected from want of sleep, so she reluctantly came to the hospital. There was some fulness over and below the pectoralis major, and extreme tenderness both there and in the axilla, but there was no specially tender spot, no redness of the skin, no fluctuation, no history of a rigor, and no glandular enlargement to be felt. It was believed to be a deep-seated abscess, so a long narrow bistoury was carefully introduced, and some laudable pus escaped; the opening was then enlarged by means of dissecting forceps. There was a free discharge; and the next day the patient expressed herself as being quite well; nothing but a sinus remained, which healed by the 27th, and the patient was discharged. She, however, returned on June 15th, with some œdema of the arm, which, under local friction and the administration of quinine and iron, disappeared.

STANLEY HOSPITAL, LIVERPOOL.

UNUNITED FRACTURES OF HUMERUS, RADIUS, AND ULNA, SUCCESSFULLY TREATED; REMARKS.

(Under the care of Mr. ROBERT JONES.)

CASE 1. *Ununited Fracture of the Right Radius.*—J. K——, aged forty, a sailor, fractured his right radius on the way to New Zealand. The captain of the vessel undertook its treatment for the first two months, which consisted in the application of the usual side splints. The patient on landing procured a surgeon, who proclaimed non-union, and persisted in the use of splints for a further period of six weeks. No success, however, accompanied this, and, in J. K——'s own words, "For four months once a week the doctor took hold of my arm and elbow and shook it for five minutes." The patient subsequently returned to England; and in August, twelve months after his mishap, he was admitted as an out-patient to the Stanley Hospital. The radius was ununited at the junction of the middle with the upper third. Around the fractured ends some thickening was perceptible. He complained of pain at night, more especially when the previous day had witnessed much use of the arm. He was quite unable to do heavy lifting, and any attempt at closing the hand firmly produced "shooting pains" around the elbow. Furthermore, a dependent position of the arm invariably gave rise to an unbearable feeling of fulness at the seat of fracture.

CASE 2. *Ununited Fracture of the Ulna.*—R. S——, a sailor, aged fifty, became in October last an out-patient at the hospital. On examining him an ununited fracture was found at the middle of the ulna. The ends were freely movable and thickened, and the skin over the seat of fracture much hypertrophied. The subjective symptoms were, pain at night, loss of power in the limb, and violent neuralgic pains during damp weather. He gave the following history: Twelve months previously he broke his arm in a pugilistic encounter on the plains of the Argentine Republic. It was plastered next day by a practitioner, who advised the removal of the dressing in about a fortnight. This injunction the patient obeyed while at sea, but necessarily with unpleasant results. On his arrival at a foreign port, a doctor applied more plasters and advised more rest. For five weeks this treatment was adopted with no improvement save in the matter of pain. Three months later the patient arrived in England, where he immediately sought advice from a medical gentleman, who proposed cutting down upon the fractured ends and excising them. This procedure he would not submit to.

CASE 3. *Ununited Fracture of the Surgical Neck of the Humerus.*—J. R——, fifty-six, was admitted an out-patient for fracture of the surgical neck of the humerus. He had met with the mishap the day before, and on his admission the contusion and swelling were so formidable as to render the application of splints quite out of the question; nor were these appearances sufficiently modified to admit of the use of supports until the ninth day, when the arm was immovably fixed. With the exception of the usual weekly trimming, this fixity was undisturbed for seven weeks, at which time there was absolutely no union. Three weeks more of anxious waiting and withal no change.

Remarks by Mr. JONES.—In the treatment of these cases I followed the method introduced to the profession by Mr. H. O. Thomas—that known as "percussion." Of this there are two varieties. The one consisting in severely percussing the limb over the seat of fracture at long intervals; the other in its daily but gentle performance. Whichever plan be adopted elastic bands should also be tied above and below the fracture to induce local congestion and thereby facilitate the reparative process. More especially is this necessary at night time, when the circulatory system is less active than during the day. The hammering is performed with an instrument covered by an indiarubber cap, so as not to lacerate the soft structures. In its absence, however, anything almost will suffice. In Case 1, the bone being somewhat deep seated, I adopted the method of severe hammering, which I performed once a week. The patient tolerated it very well and complained but little of the pain, although the indiarubber tubes tied round his at arm at night made him very restless. I applied no splints, but merely permitted the carriage of his arm slung in hammock-like fashion. This lasted five weeks. After each beating a good deal of swelling and even some contusion marked the occasion. At the end of the fifth week, having noticed a decided thickening of the ends of the bone, I applied splints for four weeks, removing them in time to find union complete. Case 2 is more interesting because more rare. In treating the patient I dispensed with the elastic tubes, and the bone being superficial it was, of course, better to try the gentle mode of percussion than that adopted in Case 1. Accordingly I hammered twice a week and kept the splints firmly applied. In a little over four weeks union was firmly established. In both these cases the treatment gave the patients hardly—if indeed any—more inconvenience than they had already endured. Case 3 differs from the others in being a less confirmed non-union. The patient was ten weeks in splints after a primary delay of nine days; and it is impossible to say but that another month's continuance would have produced union. I thought it best, however, not to trust to this alternative, and, using my fist for a hammer, I worked away twice a week for nearly two months, with completely satisfactory results. I may mention that the elastic tubes may be applied immediately after the gentle method, but it is best after the severe mode to wait until the local irritation commences to subside, and thereby prolong it. Should the contusion be very marked, it would, of course, be unwise to apply them at all. As a matter of detail, I may add that the tubing should not always be tied to the same spot, or else ulceration may result. Generally speaking its application at night-time is quite sufficient, and affords the arm very acceptable respite during the day.

THE New Orleans City Lunatic Asylum has been aboli-hed and its inmates transferred to another institution. This step, it is stated, has been taken in consequence of the exposure by a novelist, Mr. G. W. Cable, of serious abuses in the asylum.

Medical Societies.

ROYAL MEDICAL & CHIRURGICAL SOCIETY.

Dislocation of the Foot, with Version and Torsion of the Astragalus. — Ophthalmoplegia Externa, complicating Graves's Disease.

THE first meeting of this Society after the vacation took place on the 24th inst., Mr. John Marshall, F.R.S., President, in the chair. At the commencement of the business of the evening, the President directed the attention of the Fellows present to certain proposed alterations in procedure initiated by the Council, comprising increased facilities for the discussion and reading of papers, the insertion of debates in the Proceedings and the exhibition at the meetings of scientific inventions, anatomical and pathological preparations, &c.

Mr. RICHARD BARWELL read a paper on Dislocation of the Foot with Version and Torsion of the Astragalus, of which the following is an abstract. Dislocation of the astragalus is not uncommon, the bone, displaced from the socket formed by the leg-bones as well as from the rest of the tarsus, receiving, in nearly all instances, a twist, so that its surfaces look in abnormal directions. Another very rare form of injury is that of which the following is an example: G. F——, aged twenty-eight, received the injury by the overturning of a gig that he was driving, he falling on the right foot. The foot was greatly inverted, the heel raised; the inner malleolus was much obscured, the outer very prominent. The round head of the astragalus was in front of and below the external malleolus. Running from the head to the upper part of that malleolus was a ridge of bone convex outward. A small wound a little way up the leg communicated with the seat of injury. Attempts at reduction, even though the Achilles tendon was divided, were ineffectual. Mr. Barwell excised the astragalus. It was in its normal place in the tibio-peroneal socket, but was twisted, so that the trochlea looked outward, and rested against the articulating face of the outer malleolus. The man did extremely well; he was discharged in three months, walking with crutches, and was shown at the Society's meeting, walking well without any assistance from crutch or stick. After a few remarks on the difficulty of nomenclature in dislocation about the tarsus, the author referred to Malgaigne's description of version and torsion "*sur place*," the former referring to a turn of the astragalus on its perpendicular axis. Of these Malgaigne gives four examples, and the author had collected two others. They all, with one exception, were inward. Torsion, by which he means a twist on the antero-posterior aspect, is in reality more rare, although it would appear on first sight more common because Malgaigne quotes six cases; but on examination of the original records, these changes he found to be not *sur place* save in one case, Dupuytren's—and even here the bone was nearly extruded—and one preparation, the history of which is unknown, and in which the turn is very slight. The author's case is the only one in which a diagnosis has been arrived at during life, and, as far as can be ascertained, the only one in which the bone turned a quarter of the circle, and lay fairly in the tibio-peroneal socket. An appendix was added giving a short description of every case both of torsion and version in corroboration of these statements.—Mr. SPENCER WATSON, after remarking upon the rarity of dislocations of the astragalus, referred to the case of a girl who sustained a compound dislocation of the bone outwards, necessitating its excision. The result of the operation was very satisfactory, for having seen the patient a few years afterwards he found that there was free movement at the ankle and a normal appearance of the foot. Such a result was encouraging for the ultimate issue of Mr. Barwell's case.—Mr. BARWELL explained the grounds upon which he arrived at a diagnosis in his case—viz., the projection outwards of the convexity of the trochlear surface of the astragalus. He exhibited a preparation of a foot after excision of the astragalus, showing bony union of the os calcis, scaphoid, and tibia—and believed this always took place—the subsequent mobility occurring at the tarsal joints in these cases, and not at the ankle. He referred to the fact that Malgaigne had misread some of the descriptions of astragalus dislocation, and stated that he excised the bone in preference to attempting its reduction, because it was detached from all sources of its nutrient supply.—The PRESIDENT confirmed Mr. Barwell's statement as to the discrepancies arising from imperfect descriptions of such injuries, and pointed out that the astragalus differs from all the other tarsal bones in having no tendon inserted into it. Its main connexion was with the broad astragalo-calcaneal ligament, which must be torn through in the dislocation, thus seriously damaging the vitality of the bone, and leaving the surgeon no alternative but its speedy removal.

Dr. FRANCIS WARNER then read a paper on Ophthalmoplegia Externa complicating a case of Graves's Disease. The patient was a woman twenty-five years of age, and was the subject of Graves's disease of four years' standing. There was marked mental excitability, and she was frequently attacked with gastric crises, vomiting, dyspnœa, and palpitation. Both eyes were nearly immobile, a condition not accounted for by proptosis; this had existed five months before admission into hospital. Limitation of movements was not equal in the two eyes, and was greater in the horizontal than in the vertical directions; double ptosis was marked. There was also bilateral paresis of the seventh and fifth pairs of nerves, and marked tremor of the legs. There appeared to be no evidence of syphilis. Under treatment the goitre subsided, and the general condition greatly improved, but the ophthalmoplegia remains. The unequal amount of paralysis of the two eyes is taken as some evidence of an independent nerve-centre for the movements of either eye, and this is supported by observations in infants in deep sleep and adults in coma, when either eye may be seen to move separately and independently. Again, the greater limitation of movement in the horizontal as compared with the vertical direction is pointed out as probable evidence that separate centres govern these movements respectively.—Mr. POWER pointed out the reasons in favour of regarding Graves's disease as dependent on lesion of the cervical sympathetic, especially the cardiac and the gastro-intestinal derangements. In Dr. Warner's case the protrusion of the eyeball alone was not sufficient to account for its impaired movements, and there was evidently independent oculo-motor paralysis. Corneal ulceration was very rare in Graves's disease, and he attributed it in this case to inability to move the eyeball upwards beneath the lids. In this case there were evidently cerebral lesions superadded to those of Graves's disease.—Dr. ALTHAUS had never met with the association of Graves's disease and ophthalmoplegia. Although the symptoms of Graves's disease point to lesion of the cervical sympathetic, yet in many carefully recorded cases no such lesion had been found. Syphilis was the almost invariable cause of ophthalmoplegia, whether internal or external. Speaking of Mr. Hutchinson's view as to the localisation of lesion of the lenticular ganglion in internal ophthalmoplegia, and of the nucleus of the third nerve in the aqueduct of Sylvius in external oculo-motor paralysis, Dr. Althaus remarked that recent observations (pathological and experimental) in Germany pointed to the existence of centres governing the iris and ciliary muscle in close proximity to the third nerve nucleus. Again syphilitic lesions were often widespread (e.g., ophthalmoplegia might complicate locomotor ataxy) and it was conceivable that both the centre mentioned and the cervical sympathetic were involved in this case. He also referred to the persistence of ophthalmoplegia and its intractability, as well as liability to relapse, although some amelioration may be produced by large doses of iodide of potassium.—Dr. SAVAGE had seen many cases of Graves's disease in the insane, but never associated with ophthalmoplegia. In two cases examined post mortem he had failed to find any lesion of the sympathetic; but in one there was disorganisation of the suprarenal bodies. Although Graves's disease was a nervous disease, it exhibited three or four different conditions, and was met with in general paralysis of the insane as well as with other derangements.—Dr. B. O'CONNOR said that in some of Graves's earlier cases the thyroid enlargement was temporary, and in one case a peculiar form of dyspnœa was attributed to temporary dilatation of the aorta pressing on the trachea. He suggested that the cardiac ganglia might be the seat of lesion. In later cases described by Graves, the goitre was more permanent, and a marked difference was observed between the carotid and radial pulse.—Dr. WARNER, in reply, pointed out the large area involved in this patient, there being paralysis of the fifth and seventh nerves as well as of the third, and the tremor of the feet indicated some

change in the spinal cord. There was no evidence at all of syphilis; and the corneal ulcer was purely local, and probably due to the lesion of the fifth nerve. Mercurial treatment has been tried but abandoned; and the diminution in the thyroid swelling followed the application of cold by Leiter's tubes. This improvement under cold suggested sympathetic disorder, the ophthalmoplegia remaining.

At the close of the meeting the President directed attention to two scientific instruments upon the table. One was an apparatus designed by Mr. Robson of Leeds, for the purpose of producing a dry antiseptic vapour. It consisted of two metal U-shaped tubes in connexion with a foot-bellows, one tube being filled with cotton wool to filter the air, and the other with pumice to receive the antiseptic fluid—e.g., eucalyptol. The apparatus had been used in cases of ovariotomy, and it was intended to replace the spray. The other instrument was the ingenious metallic clinical thermometer originally shown to the Medical Congress last year by Messrs. Mayer and Meltzer, who had since perfected it. It is constructed on the principle of a Bourdon tube, which is filled with a highly expansive fluid, and which in expanding moves a pointer set on a dial by means of a rack and pinion.

MEDICAL SOCIETY OF LONDON.

Cranial Osteophytes in Congenital Syphilis.—Gastrostomy.—Inflammation, Suppuration, and Ulceration of Tongue.

AT the meeting of this Society on the 23rd inst., Mr. F. Mason, President, in the chair,—

Dr. RADCLIFFE CROCKER showed the Skull-cap of a child aged a year and ten months, with well-marked Osteophytes from Congenital Syphilis. The living case was shown last year with extreme anæmia, enlarged spleen, and cranial thickenings, but with no other signs of syphilis. The family history of miscarriages, and early deaths was corroborative. The child died from bronchitis. The thickenings were well marked over the frontal and parietal eminences, and on each side of the sagittal suture posteriorly. The borders of the anterior fontanelle were quite thin. The rough drab-coloured surface of the new bone was in marked contrast to the smooth, white, healthy bone.—The PRESIDENT thought there was very little evidence of congenital syphilis in the case; and Dr. CROCKER said that he relied on the anæmia and enlargement of spleen for his diagnosis, which was confirmed by the existence of the cranial osteophytes.

The PRESIDENT related the particulars of a case in which he had performed the first stage of Gastrostomy. The patient was a man aged sixty, who had carcinoma of the left tonsil, which was growing so rapidly as to interfere with deglutition and respiration to a dangerous degree. The general details of the case had already appeared in THE LANCET of Oct. 14th; the specimen showed the kind of union that had taken place between the parietal layer of the peritoneum and the visceral layer of the stomach, an amount of union not sufficiently strong to justify opening the cavity of the stomach. Had life been prolonged a few days the union would probably have been thoroughly solid. Death took place on the third day after the operation, partly it was thought from exhaustion, but directly from a sharp attack of dyspnœa, for which tracheotomy was performed with temporary relief only.—Mr. BRYANT said it was important to determine when the second part of the operation—viz., the perforation of the stomach—should be performed. The parietal peritoneum should be included in the stitches, of which six or eight should be put in close together. Four should be stout, the rest fine ones. His own experience was too small to accurately fix the date for opening the viscus. In one successful case of his, vomiting displaced the adhesions and one of the stitches before the incision was made into the stomach; he therefore delayed the second part of the operation. In some cases the stomach may be opened on the third day, but if the adhesions are not firm it should be left till the fifth or eighth. In a case of ovariotomy performed by him fifteen or twenty years ago, treated with the clamp, death having occurred on the third day from bronchitis, the abdominal cavity was found to be already closed by adhesions from the external wound.—Mr. GOULD had had lately two cases of gastrostomy. In the first the stomach was opened on the third day with difficulty, for the mucous membrane was corrugated and separated from the muscular and serous coats. The tenotome had to be introduced quite up to the hilt before perforating it. Death occurred from peritonitis forty-eight hours after; the adhesions were extremely slight. The patient was in a state of extreme starvation. He expected to find the stomach thinned; and he had therefore been led to make the stitches too shallow. In the second case the dyspnœa was first relieved by tracheotomy. The stomach was opened on the eighth day after the first part of the operation, and food was introduced several times a day. Peritonitis set in two days after, and death took place on the fifth day. The adhesions were firm, and the cause of the peritonitis was not apparent. Perhaps the injections of food were too large and too frequent.—Mr. E. OWEN preferred Mr. Mason's course of waiting and performing gastrostomy when necessary to that of excising the tonsils.—Dr. HEYWOOD SMITH asked how the antiseptics were managed, and spoke of the value of the eucalyptol spray in abdominal operations.—Mr. BRYANT had introduced his plan of the two stitches to obviate the difficulty met with in Mr. Gould's case. Much care should be exercised in feeding, and for the first few days only warm milk should be given in small quantities.—The PRESIDENT, in reply, said that he had no experience of the eucalyptol spray; his patient suffered from carbolic poisoning, though the exposed surface was so small. The spray was used throughout the operation. As regards the number of stitches, he thought four were enough, and in this case they were closely set. In the future he should use two needles—a surgical needle to go through the abdominal walls, and an ordinary sewing needle to perforate the stomach.

Mr. BRYANT read a paper on some Cases of Inflammation, Suppuration, and Ulceration of the Tongue. He detailed examples of abscess due to injury as well as to idiopathic causes, and showed how this affection has a tendency to get well, and more particularly after an early puncture. He recorded two examples of hydatid of the tongue. The subject of chronic superficial glossitis then received attention, and it was illustrated by cases as well as by a preparation. Superficial ulcerations were then described, and some good examples quoted of the simple dyspeptic ulcer. Ulcers due to local irritation were then described, and cases quoted, in one of which the ulcer had existed for two years, and had been mistaken for a cancer. Deep-seated ulcerations were fully considered, and the differences between the syphilitic, epitheliomatous, and tubercular forms dwelt upon. The tendency for the chronic syphilitic disease of a tongue to pass into cancer was emphasised, and the danger of not recognising the tendency to the full pointed out. The connexion between epithelial cancer of the tongue and ichthyosis was demonstrated, and the local character of the cancer noticed. The necessity for the early removal of a cancerous tongue was strongly enunciated, and some good cases quoted in which a long immunity from the disease, if not a cure, had been obtained. The different modes of operation were then discussed, and statistics given of operations, in which the mortality as a whole from the operation was shown to be about 10 per cent. Amongst the advantages of the operation was advanced the fact that when a cure does not take place great comfort is given, and that a return of the disease is more likely to occur in the glands of the neck than in the tongue itself. Time not permitting of some remarks being made on tubercular disease of the tongue, it was deferred to another occasion. The paper was illustrated by drawings and preparations.—The PRESIDENT said that in his experience patients seldom survived more than two years after removal of the tongue. Cases of abscess and hydatid of the tongue are rare, and so are cases of cancer in persons under forty. He had operated in a case of cancer of the tongue in a lady thirty-three years of age.—Dr. ROGERS asked why Mr. Bryant had given up the use of the galvanic écraseur.—Mr. HUTCHINSON had had similarly favourable experience in operations for the removal of the tongue in cancer. In very few cases was a second operation on the tongue required. Of course the disease returned very frequently in the lymphatic glands. He agreed with Mr. Bryant that the galvanic écraseur was a suitable and convenient instrument, but preferred the wire écraseur because (1) of less liability to secondary hæmorrhage, and (2) the wound takes on a more healthy action after the cold écraseur.—Mr. H. MORRIS spoke of the importance of Mr. Bryant's statements as to the frequency of lung complications in cases not operated on as well as in cases operated on. Two of his own cases related in his paper last session had now lived over two years after the operation. He did not recommend ligaturing the lingual artery in excising, as hæmorrhage was so easily controlled; but in a case of cancerous

hæmorrhage from the mouth he had ligatured both facial and lingual arteries (the former to avoid risk of secondary hæmorrhage) with good result, hæmorrhage ceasing, and the patient living for two years after. At the post-mortem examination the usual foul, sloughy condition of mouth was wanting. He asked if Mr. Bryant considered that abscesses of the tongue always healed readily. In one case he was surprised at the rapid healing of an abscess.—Mr. WALSHAM had also observed rapid healing of lingual abscess. He alluded to the advantage of the cord compressor in removal of the tongue in preventing secondary hæmorrhage and obviating shock.—Mr. BRYANT, in reply, was himself surprised at the favourable results of his statistics of removal of the tongue. He strongly believed in cancer being local at the outset. He was not quite satisfied of the superiority of the ordinary écraseur over the galvanic, and did not recall many cases of secondary hæmorrhage after the use of the latter. In one case this was due to the haste needed in operating. In using the cord it had once snapped during the operation, and he preferred a wire to a chain. Mr. Morris's allusion to ligature of the lingual artery was valuable, and he agreed with Mr. Hutchinson as to the infrequency of local recurrence. In one case he removed what was thought to be a recurrent mass a year after excision of the tongue. The patient had lived three years and a half since without further recurrence.

OBSTETRICAL SOCIETY OF LONDON.

A MEETING of this Society was held on Wednesday, Oct. 4th, Dr. Matthews Duncan, President, in the chair.

Spurious Hermaphrodite.—Dr. FANCOURT BARNES showed a child (living) which presented malformations such as those classified by Sir James Simpson under the title of "spurious hermaphroditism." He could find no trace either of testes or of uterus, but thought the child most likely a male.—Dr. CHAMPNEYS had, in a somewhat similar case, detected the uterus by examination per rectum. — Dr. SWAYNE said that there was a specimen in the Museum at Bristol in which the external parts were like those in this case, but the internal organs those of a female.

Hypertrophy of Placenta.—Dr. HERMAN showed a specimen of hypertrophy of the placenta. It had been removed piecemeal, and a large part left at the patient's house. The portion exhibited weighed more than four pounds. To the naked eye its structure did not differ from that of normal placenta. The child was decomposed when born.—Dr. ROBT. BARNES had observed in some cases of hypertrophy of the placenta, dropsy of the placenta, and ascites and anasarca of mother and fœtus. Possibly the placental villi were overdeveloped in order to find enough pabulum in the hydræmic blood.

Degeneration of Placenta. — Dr. CHAMPNEYS showed (for Dr. Murray) a placenta exhibiting fibrinous degeneration in the uterine and calcareous degeneration on the fœtal surface. The child was born alive.

On an Obliquely Contracted Pelvis of Unilateral Synostosis.—Dr. CHAMPNEYS read a paper on this subject. The pelvis was that of a child, aged between seven and fifteen, in which the changes at puberty had already slightly commenced. At this point the left sacro-iliac joint became inflamed, leading to synostosis of part of the articular surface. The left half of the sacrum was dwarfed, and this bone rotated so as to look somewhat to the left. The left half of the pelvis was narrowed, the pubic symphysis driven to the right, and its left half displaced behind the right. But compared with most Naegele pelves, the outline of the brim was less straight, there was less verticality of the ilium than usual, and there was no evidence of transverse rotation of the left os innominatum on its acetabular axis. The author considered the specimen one of a half developed obliquely contracted pelvis of unilateral synostosis, most instructive in its bearing on the production of the typical pelvis of Naegele. —Mr. GRIFFITH thought that the synostosis was congenital. If so, Dr. Champneys' theory would require modification.—Dr. CHAMPNEYS thought the joint showed clear evidence of disease.

Transverse Septum in the Vagina.—Dr. GERVIS described a case of the above malformation. The patient was aged twenty-two, and menstruated regularly. She sought advice on account of pain in micturition, due to a urethral caruncle. About an inch and a half or two inches from its orifice the vagina seemed to end in a cul-de-sac, having on either side a pouch, giving at first the impression that there was a double vagina. In the left cornu was a small opening admitting a probe into the space beyond. The hymen was present. The uterus could be felt per rectum. The septum was divided with the thermo-cautery, giving exit to a quantity of brownish mucus. A granular erosion surrounded the os uteri. The caruncle was at the same time removed. The patient did well, and the endocervicitis began immediately to improve when freed from the apposition of retained secretions. The author remarked on the value of the thermo-cautery in lessening the risk of septic infection in such cases.

Case of so-called Imperforate Hymen.—A paper on this subject, by Dr. MATTHEWS DUNCAN, was read. He was induced to relate the case by three circumstances. 1. There was a remarkable absence of any kind of suffering during nearly the whole time of the development of the disease. The patient had never menstruated nor suffered from any uneasiness in connexion with that function until eight months before admission, when she was told by a medical man that she had a lump in the lower belly. Since then she had suffered from irregular achings. The author thought the probable explanation of this was that the uterine body was not distended, for facts showed that dilatation of the uterine body was more difficult and painful than dilatation of the vagina and uterine cervix. 2. The case illustrated the treatment without any injections, which had been the subject of remarks at a recent meeting of the Society. An incision was made by Paquelin's cautery knife. About twenty-five ounces of the usual treacly fluid escaped, about twenty ounces on the following day, and the last of it on the fifth day, in all about fifty ounces. At no time had it any fœtor. No hypogastric pressure or interference with the flow was permitted. A piece of carbolised lint was put to the vulva. The patient made an uninterrupted recovery. He thought the risk of peritonitis was increased by the washing out sometimes practised. He thought the cautery knife was preferable to any other mode of making the incision, because its wound was not an absorbing surface. 3. The condition of the pudendum, rendering the term "imperforate hymen" erroneous and misleading. The vagina was closed by a membrane upon which the hymen could be seen entire and healthy, and after the operation the hymen could be seen to have its normal position and relations. He had made the same observation in other cases, and he had seen the hymen present when vagina and uterus were both absent. On these grounds he regarded the view of M. Budin (that the hymen was nothing but the anterior extremity of the vagina) as incorrect.—Dr. ROBERT BARNES said that in these cases toxæmia arose before the blood was evacuated, from decomposition of the hæmato-globulin in the retained fluid. He had not used injections; they were not called for in all cases.—Dr. GERVIS could hardly accept Dr. Duncan's view, that the membrane occupying the area within the hymen was vaginal wall. He thought the variations in shape of the hymen, and the absence of muscular fibres in it, militated against M. Budin's view.—Dr. CARTER had had under his care a case similar to that described by Dr. Gervis. He had divided the septum and the patient did well. He thought washing out was meddlesome unless the discharge was offensive or there were symptoms of septicæmia.—Dr. ROGERS mentioned a case under his own care. Some pyrexia followed the operation. The vagina was not washed out till a week after the operation, and when this had been done the pyrexia subsided.—Dr. GALABIN thought it an important question whether in these cases it was desirable to use injections immediately after an interval or not at all. The danger was greater the higher the atresia was situated. He had known of two cases of high obstruction, in which death had followed evacuation, although no syringing was used. Emmett had published a number of cases, many of them of atresia high up, in which recovery had followed treatment by injections. He generally let the fluid flow for twenty-four hours, and then began antiseptic injections. All his cases so treated had been successful. Perhaps it would be best if a perfectly aseptic condition could be maintained by antiseptic dressings.—The PRESIDENT said that Dohrn had entered elaborately into the developmental histories of vaginal closures. What he (Dr. Duncan) wished to show was that cases with blue, thin-walled bulging between the labia were generally, often erroneously, called imperforate

hymen, whereas in many, and also in cases where there was no vagina, a hymen could be distinctly seen.

New Intra-uterine Stem Pessary.—Dr. SWAYNE showed a new form of stem pessary. It consisted of a perforated vulcanite stem, which rested on an indiarubber band attached to a modification of Greenhalgh's pessary. These were introduced separately, but when *in situ* united by a silk thread. The advantages he claimed for it were that it was easily introduced, kept in place, and allowed uterine mobility, so that it was free from some of the dangers that attend stem pessaries. He should only use stem pessaries when simpler and safer means of treating uterine flexion had failed.—Dr. HEYWOOD SMITH asked what advantages Dr. Swayne's pessary had over that of Dr. Wynn Williams?—Dr. EDIS thought stem pessaries very dangerous. The position of the uterus was too much regarded, whereas its condition was the chief thing. Numbers of cases of pelvic peritonitis occurred from the injudicious employment of stem pessaries, producing much suffering and not infrequently death.—Dr. ROGERS did not think Dr. Swayne's instrument more perfect than that of Dr. Wynn Williams.—The PRESIDENT did not use any kind of stem pessary. He had known of many deaths from them, but he never knew of a case of version or flexion cured by them.—Dr. ROBERT BARNES thought stem pessaries necessary in some cases. Accidents had occurred from them, but now more scientific instruments had been contrived. He preferred that of Dr. Greenhalgh. He had cured cases of anteflexion with stem pessaries.—Dr. HERMAN had known of a death following the use of one of Greenhalgh's stem pessaries.—Dr. SWAYNE said that in his pessary the indiarubber supporting the stem was firmer than in that of Dr. Wynn Williams. He had used it many times, always with good results. He had always carefully watched the patient, and withdrawn the stem whenever it gave rise to pain or rise of temperature.

EPIDEMIOLOGICAL SOCIETY.

THE thirty-second session of the Epidemiological Society was opened on the 18th inst. by a conversazione given by Dr. George Buchanan, F.R.S., to members and friends of the Society, at University College, Gower-street. Among the distinguished company present were the Directors of the Army and Naval Medical Services, and other eminent members of the profession. Several microscopical specimens, illustrating subjects with the study of which the Society is specially concerned, were shown during the meeting. Among them, preparations of the ova and living ciliated embryos of Bilharzia hæmatobia, exhibited by Dr. Cobbold attracted special attention. The embryos were seen making vigorous movements within the firm outer shell of the ovum, which finally ruptured and allowed them to escape. The specimens were obtained from the urine of a patient who had contracted endemic hæmaturia while in Egypt. Dr. Klein also demonstrated specimens of bacillus tuberculosis in the sputum and lung from tuberculous patients, from the lung of a cow suffering from bovine tuberculosis (Perlsucht), of the bacilli of anthrax and septicæmia, of the bacilli met with in the Welbeck and Nottingham cases of ham-poisoning, and the micrococci present in the lymphatics in ovine variola, and in the blood and liver of patients suffering from infantile diarrhœa. A section through the tongue from a case of Actinomyces bovis also showed very beautifully the stellate masses of fungus, surrounded by a deeply-stained layer of inflammatory exudation, containing numerous leucocytes. Specimens of the embryo filaria sanguinis hominis from the blood of a patient suffering from chyluria, and from the Chinese mosquito, were exhibited by Dr. Stephen Mackenzie. Examples of trichina spiralis in the muscles of a wild boar, of dracunculus embryos, of the micrococci of diphtheria, septicæmia, pyæmia, and ulcerative endocarditis, and of the ringworm fungus (trichophyton tonsurans) artificially cultivated were also shown by Drs. Bastian, Gibbes, Henderson, Mackenzie, and Mr. Malcolm Morris.

The first ordinary meeting of the Society will be held at University College on Nov. 1st, when a paper will be read by Dr. Norman Chevers, C.I.E., "On the Sanitary Defects of the Site of London and its Suburbs."

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

THE first meeting of this Society was held on Friday, October 6th, at the West London Hospital, Hammersmith. The President, Dr. Hart Vinen, was in the chair, and over eighty-three gentlemen were present.

The PRESIDENT delivered an inaugural address, in which he thanked the members for the honour they had conferred upon him by electing him their first President, and congratulated them on the large number of practitioners who had already joined their ranks, which augured favourably for the future progress of the Society. After alluding to the numerous Societies which exist for the prosecution of scientific pursuits, and the value of their labours to the general welfare of mankind, he urged the members to look to science as the best aid to the successful practice of their profession, and as not without its moral results. "For if the suggestion of Newton, that in proportion as natural philosophy is improved in its various branches, the bounds of moral philosophy will be enlarged also—if this be true, as it undoubtedly is, we may point to the labours of our scientific men as not only serving to extend the boundaries of our intellectual horizon, but as exercising a refining and humanising influence over man's moral nature. But there is another light in which we may regard such societies as this, I mean their social aspects. The daily routine of professional duties too often restricts medical men to a very limited orbit, and furnishes them with few occasions for friendly intercourse with their brother practitioners. Here they have opportunities of meeting periodically on common ground, of exchanging opinions on professional and other topics, and by other men's experience enlarging and correcting their own. No remedy is so effectual for healing professional animosities as frequent intercommunication; and if I were asked to prescribe a panacea for their prevention, I should recommend an occasional dinner at the Star and Garter. Some may think this view of the matter savours too much of the sensual, but the periodical recurrence of such a social reunion would, perhaps, be more productive of good results than the strictest code of medical ethics." Dr. Vinen then alluded to the fact that more than twenty years had elapsed since he had filled the presidential chair of another medical society, and referred briefly to the most prominent changes which had taken place during the interval, especially dwelling on the germ theory of disease, which recent researches had done so much to establish, and the benefits which resulted to public health from the advance of sanitary science, in which he claimed for the medical profession the honour of being the foremost workers.

Dr. BURNEY YEO then delivered the address, which we published *in extenso* on October 14th.—Dr. THUDICHUM said he was much interested in Dr. Yeo's paper, though he did not agree with him. There was no proof that the bacteria were destroyed by his process. Those who had examined the expectoration of a phthisical patient and observed the bacilli present in it must have been impressed with the awful nature of the disease; the incalculable number present in the organ seemed to him to render the question of total destruction mathematically impossible. Dr. Yeo admitted that advanced cases were not suitable for this treatment, but he thought that there was no specific which did not cover all cases. He would ask how could these antiseptic inhalations reach the brain, or heart, or any other organ (except the lungs) which might happen to be the seat of tubercular disease?—Dr. ALDERSON thought that great benefit was to be derived from the use of the respirators, and was most certainly ready on this, as on other points, to reiterate the President's cry for "More light."—Dr. RAYNER also endorsed Dr. Yeo's theory.—Dr. BROWNE wished to know how long it was necessary to wear the respirator at a time.—Mr. JACK was of opinion that whether the bacilli were destroyed or not, the process, in whichever form adopted, put the patient into a condition calculated to prevent a nidus being formed for the bacilli.—Dr. THOROWGOOD had no great experience on the subject, but he had most certainly noticed great improvement in those cases which he had so treated. He was accustomed to order the respirator to be worn for an hour in the morning and evening; he found it promoted expectoration. Of the

various antiseptics he himself preferred creasote. Sea air as obtained in a voyage was, too, he thought, most efficacious in the early stages of the disease; later on, it seemed to do more harm than good.—Dr. YEO, in reply, said he did not wish in the remarks he had made to dogmatise in any way, he was only anxious to show that the theory he had been laying before them had a scientific basis. He must say, in answer to Dr. Thudichum, that he was unaware of his having used the expression "specific"; it was not his custom to use the word, and he failed to see anything detrimental to his theory in the fact that advanced cases were not suited to the treatment. As regards the alarming number of bacilli pictured, he would simply suggest that if Mr. Lister had frightened himself about the number of organisms to be encountered there would never have been any such thing as antiseptic surgery. The advantage of the respirator, as suggested by himself, consisted in its lightness and comfort in wear, in fact to its not being a muzzle; his patients wore theirs as long as possible during the working day, it being only necessary to remove it while eating or drinking. He agreed with Dr. Thorowgood in preferring creasote, but he had used eucalyptus and pine-wood oil with great advantage, though the latter was to some rather irritating. He saw no reason why still more direct treatment should not be attempted, and he hoped soon to try the effect of injecting by the long needle of an aspirator, a small quantity of bichloride of mercury.

Mr. SAVILE KENT and Mr. BAKER showed specimens of Bacilli, Bacteria, &c.

Reviews and Notices of Books.

Medical and Surgical Aspects of In-Knee (Genu Valgum); its Relation to Rickets, its Prevention, and its Treatment with and without Surgical Operation. By W. J. LITTLE, M.D., F.R.C.P.; assisted by E. MUIRHEAD LITTLE, M.R.C.S. Illustrated by upwards of 50 Figures and Diagrams. London: Longmans, Green, and Co. 1882.

THE appearance of this book at a time when surgeons are numbering their osteotomies by the score, and even by the hundred, is very opportune. The authors regard "in-knee" as an affair of the joint, as the deformity to the production of which there is a natural tendency in the articulation, and to which many morbid changes in and around the joint conduce; the insufficient support of the joint by the surrounding muscles being one of the main direct causes of the deformity. They by no means share in the opinion that "in-knee" is in all cases due to rickets. "In the several forms and subforms of genu valgum resulting from different diseased actions, the point on which the progress of distortion may be said mainly to turn is undue contact of the external condyle with the opposing part of the tibia, and consequent arrested development or deterioration of these parts. The identity of distortion and mechanical changes is undoubtedly due to the identity of mechanical acting forces." The pathological views of the authors are briefly expressed in this passage, and they hold that "*enlargement* of the internal condyle is not pathognomonic of any form of in-knee; that the essentially most damaged parts of the joint are the external condylar part, and the external articular portion of the tibia." As regards treatment, our authors are opposed to much that is now in vogue, and to all that partakes of any roughness or severity. They admit that there are some cases of neglected in-knee in which osteotomy is the only or the best mode of relieving the deformity, and of all the ways of performing this operation for genu valgum they prefer that practised so often and so successfully by Macewen of Glasgow. The authors' treatment aims at correcting the deformity, and preventing its re-formation until the joint surfaces have recovered their proper shape and the muscles and ligaments are able to support the joint. They say: "A long-continued experience has shown that to cure in-knee, besides diet and hygiene, two things are necessary—viz., to keep the knee extended during the treatment by an unyielding apparatus, and to employ a similar contrivance to attain adduction of the leg." It is with justice insisted on that this mechanical treatment requires great skill on the part of the surgeon, and demands his personal attention, and should not be left to friends or to the instrument maker. To the neglect of these precautions much of the alleged ill-success of the mechanical treatment has been due, and children who ought to have been rescued by proper management have been sent into life crippled.

Health Resorts and their Uses. Being Vacation Studies in various Health Resorts. By I. BURNEY YEO, M.D. Lond. Pp. 316. London: Chapman and Hall. 1882.

THIS work consists chiefly of a reprint of articles which have appeared in *The Times* and *Fortnightly Review*, and may, therefore, be considered as having been intended chiefly as a guide to invalids and others in the selection of suitable health resorts; but it also contains much information which must prove valuable to those members of the profession who have not had the opportunity of personally visiting these places. In an introductory chapter Dr. Yeo discusses at some length the important differences between the action of sea and of mountain air upon the system, and points out in detail their respective properties. He then asks the practical questions, Who should go to the mountains? Who should go to the sea? And who should go to neither? For the answers we must refer our readers to the book itself, where they will find the conditions stated which ought to influence them in deciding this vital point. Of the high mountain resorts, the author gives a very full and interesting description of those in the Upper and Lower Engadine and of Davos Platz, with special reference to the influence of a prolonged residence on cases of incipient consumption. Of Davos Platz he appears to entertain a favourable opinion as far as the climate is concerned, but calls attention to the very serious evils of overcrowding and over-building, which have arisen from its growing popularity, and on that account is disposed to recommend St. Moritz, in the Upper Engadine, as being preferable, except "to the feebler classes of pulmonary invalids who are also the victims of more advanced disease." A short account is given of the principal health resorts of the Pyrenees, and the cases to which they are most likely to prove beneficial, and also of some of the other French watering-places, especially Vichy, Royat les Bains, Mont Dore, and La Bourboule. A chapter is devoted to some of the more important Rhenish spas, with special reference to "their sanitary conditions, and to the provisions which obtain in them for the prevention of the origin and spread of epidemic and contagious diseases," and with a view to provide a detailed professional estimate of their respective merits. The book concludes with a couple of chapters on the important and interesting subject of winter quarters for those who desire to avoid the damp, cold, and variability of our winter climate. Dr. Yeo has gone fully into the characteristics of the climate of Egypt, Mogador, Tangier, Algiers, and the various resorts on the Western Riviera. He has given the climatic, sanitary, and social conditions of these in sufficient detail to enable medical men to select the locality most likely to benefit their patients, and the latter to choose that which is best suited to their habits and tastes. To those members of the profession who are consulted on the subject of health-resorts for the delicate and the diseased, Dr. Yeo's book will afford much useful information in a pleasant, readable form, and may aid them in the selection of the most suitable residence for their patients. We would, in conclusion, only remind them of the importance of impressing upon their patients how much of the benefit to be derived from these resorts depends upon the care they take of themselves, and

the precautions which are necessary on the part of invalids to avoid the dangers, even in these comparatively mild climates, to which they are too apt to expose themselves.

Quarterly Journal of Microscopical Science. No. LXXXVIII. Edited by Professors LANKESTER, DYER, and KLEIN. London: J. & A. Churchill. 1882.

THIS part opens with a tribute of regret to Professor Balfour, whose premature death on the Swiss Alps, in July last, must be a subject of deep regret to all who are interested in the advancement of that branch of physiology in which he took so deep an interest—embryology. The University of Cambridge, in recognition of the importance of his subject, had created a professorship in it, and had committed to him the duties of the chair. It will be difficult to find his successor.

Amongst the most important of the papers is one by Dr. Horst on the Development of the European Oyster, a subject of considerable obscurity and very difficult to elucidate, since the embryos not only pass their first stages of development within the pallial cavity of the mother, but the impregnation of the eggs takes place also internally instead of externally, and it is possible that the eggs and the spermatozoa even meet in the efferent ducts of the genital gland. The successive stages have to be followed in a series of animals, since the opening of the oyster by the division of the adductor muscle is fatal to it, and the development of the spat is arrested. The segmentation appears to be the same as that of other Lamellibranchs; it passes through a gastrula stage. The shell gland early appears, and is of great size, arising by an invagination of the epiblast. It is an azygous formation, so that there are not two glands for the two shells. Some good illustrations of the first stages of development in the oyster are given in the plate which accompanies the paper. Mr. H. Marshall Ward gives the result of his researches on the Morphology and Life History of a Tropical Pyrenomycetous Fungus. Mr. Blomfield describes the thread-cells and epidermis of the Myxine; Mr. Hickson describes the eye of the Spondylus, one of the Lamellibranchs. The retina stretches across the eye-cup as a broad band. Mr. Walter Gardiner shows that there is an open communication between the cells in the pulvinus of Mimosa pudica; Mr. Haddon gives a short paper on the development of Mollusca, describing the earlier stages; Mr. P. H. Carpenter continues his Notes on the Morphology of the Echinoderms; Professor Lankester describes the vertebration of the tail of Appendicularia; Professor Moseley supplies some notes on the structure of Seriatopora, Pocillopora, and some other corallines, and Dr. Vincent Harris a note on the Pacinian corpuscles.

Brain. October, 1882.

THE current number opens with an interesting systematic account of "Alternating Insanity," or "Folie à Double Forme," by Dr. Achille Foville, translated by Dr. Urquhart. Dr. Obersteiner of Vienna describes some additional cases of chronic morphinism with especial reference to the mental changes which result. The pathological physiology of the nervous discharge in convulsions is the subject of some speculations by Dr. Mercier; Dr. Ross contributes several interesting observations of spasmodic paralyses of infancy, and a case of tumour of the brain, causing localised convulsions, is discussed by Dr. Hughlings-Jackson. Among the reviews the most noteworthy is a lively and trenchant criticism of Luys' "Brain and its Functions," by Dr. Bucknill, and amongst the clinical cases an observation by Dr. Ferrier, of the singular condition in which impressions on one-half of the body are referred to the corresponding point on the opposite side, termed by Obersteiner "Allochiria," a condition which is at present a physiological enigma.

ON ABSORBENT DRESSINGS, ETC.

To the Editor of THE LANCET.

SIR,—I have read with pleasure the article on the above subject, with illustrative cases, by Mr. Berry, in your issue of the 21st inst., and make a few brief notes concerning the cases. In Case 1 I find the good effects of the "dry absorbent dressing" were promoted by a little red lotion (dry?) and boracic lint. Nevertheless, an ulcer, going on to erysipelas, occurred before complete recovery, and the patient had to be removed to another ward, and appropriate treatment was employed. I imagine undue pressure caused the ulcer, and want of antiseptic dressing might be answerable for the erysipelas. In Case 2 carbolised tow (aseptic) was employed, and the case did well. Case 3 seems to have recovered in spite of everything, for the sutures ulcerated out and were replaced by strips of plaster. The flaps swelled in spite of the absorbent dressing evidently, and got well *per vim naturæ*. A week or two after this Mr. Berry performed a similar operation (on a healthy subject), for accident, who died shortly afterwards. This case is not reported. Case 4, Mr. Berry states, had been treated antiseptically previously to his taking charge of it. Now, why should he laugh at antiseptic treatment, and write his letter to you on April 15th, when on May 18th he sponged out an abscess cavity in Case 4 with a solution of carbolic acid? No doubt at the same time he sponged the new wound (through the condyles), and brought the flaps together; the natural glaze of lymph and the dressing over it prevented further access of noxious atmospheric particles to the part. Mr. Berry says he is not particular as to what material his dressings are made, or whether they be aseptic or not. From his cases we at least learn (?) what we knew before, and see once more that antiseptic dressings were followed by the best results in these cases. The fact that Mr. Berry only publishes his favourable cases takes materially from the value of his communication. Though not attached to the infirmary, I had frequent opportunities during the past year of visiting the Wigan institution; seeing many things, saying few, I came to the conclusion that Listerism, or the antiseptic treatment, are terms not fully understood there. An operation is there followed out thus antiseptically, except that—(*a*) As a rule the part to be operated on is not cleansed with antiseptics previous to operating. (*b*) The spray is not in working order to begin with, and when the steam is up the vapour plays either under the table or in the operator's face, occasionally perhaps on the wound. (*c*) The operator's hands are not invariably dipped in antiseptic fluid before operating. (*d*) The assistants may keep their hands in their pockets until required, and without cleansing them may handle the wound or the instrument, and feel the patient's pulse between whiles. (*e*) Anyone of the staff (general practitioners in the town) requires no cleansing, because his breath is antiseptic when the spray does not play on the wound, and his hands are invariably considered pure and aseptic. (*f*) The instruments are not carefully cleansed in antiseptic fluid before use. A pair of forceps used to pick up an artery is put down anywhere, and then used to secure another uncleansed. (*g*) The spray, exhausted before the operation is over, is not used when changing the dressings. (*h*) If the operation is not very successful they blame their method. I blame their method—not Lister's.

In the treatment of wounds, whether by Listerism or otherwise, I suppose we are all taught in our hospitals the value of drainage and rest. Concerning pressure, we are usually told it should be gentle and equable. Mr. Berry gives us pressure without any reference to the number of pounds on the square inch, nor whether one part should be pressed more than another. Now for absorbents. The employment of tow is no new thing, nor is the use of cotton-wool, nor lint, nor a strip of worsted, but they are the better for being aseptic. What can be more soothing to the patient than a strip of lint soaked in glycerine and applied to a swollen, painful, and raw wound of a finger?

I am, Sir, yours, &c.,

Brighton, Oct. 21st, 1882. H. ROGERS-TILLSTONE, M.R.

THE sum of £393 18s. 6d. has been handed over to the treasurer of the Lincoln County Hospital, as the proceeds of the last Hospital Saturday collection.

THE LANCET.

LONDON: SATURDAY, OCTOBER 28, 1882.

IN a previous article on the report of the Royal Commission appointed to inquire concerning small-pox and fever hospitals, we indicated the principal subjects which had been dealt with. Some of these subjects are of immediate and pressing concern in connexion with the actual prevention of epidemic disease in the metropolis; others deal with matters relating to the history of small-pox in London, to sanitary administration, and to allied topics. The principal interest for the moment centres in the past work of the Metropolitan Asylums Board, and this is entered into in much detail by the Commissioners. The report commences with a history of the constitution of that Board and of the establishment of the five hospitals under its control, together with some account of the proceedings to which the Board have been subjected as regards the Hampstead and Fulham Hospitals. Dealing next with the behaviour of small-pox both in England and the metropolis, it is shown in some valuable tables that, in London especially, whereas this disease had steadily been falling under control up to 1860, it has since then been fitfully but sensibly gaining upon us. Recognising the great source of danger attendant upon the treatment of infectious diseases in ordinary dwelling-houses, and also the fact that much of the spread of small-pox is due to the need of proper means of isolation, the Commissioners urge that the notification of infectious diseases should be made compulsory, and that it should be associated with a power of removal to hospital, not as now merely in the interests of any patient who does not happen to possess proper accommodation so far as his own welfare is concerned, but rather in the interests of the public, who are by reason of his illness exposed to danger. The notification is in the main to be made by the householder, and it is to pass first to the sanitary authority and thence to a metropolitan hospital authority—a method of procedure which will, we fear, lead to the very delay which in such cases it is so important to avoid. It is further suggested that in the matter of the provision of isolation the distinction between the pauper and the non-pauper should be abolished; that all alike who, in the interests of the public, submit themselves to isolation, should be treated at the public cost; and that the hospital authority for the metropolis should be a single body, which in its general aspect ought to be, not a pauper, but a sanitary authority. Coming next to the amount of isolation accommodation needed for small-pox cases in the metropolis, it is, after careful calculation, believed that a permanent provision of some 2100 beds would answer the needed requirements even in years of exceptional prevalence; and it is further stated that, since a large proportion of the milder attacks, as also of the convalescents, could easily be moved outside London, the existing accommodation in the Asylums Board hospitals would suffice, provided it could be used without injustice to the neighbourhoods in which the hospitals are situated.

At this point, however, the Commissioners, before making any recommendation as to how the needed small-pox hospitals are to be provided, find it necessary to inquire whether such hospitals are or are not centres of infection, and they at once admit that by some means or other the Asylums Board small-pox hospitals have caused an increase of that disease in their neighbourhood. The cases of the Hampstead and the Fulham Hospitals are specially considered, and a well-deserved tribute is paid by the Commissioners to the remarkable report by Mr. W. H. POWER on the influence of the latter hospital. From this report the Commissioners specially quote the proofs, statistical and other, which go to show that in some way the Fulham Hospital, whilst in use for the reception of small-pox patients, did on several occasions most injuriously affect the surrounding neighbourhood. Similar, though less complete, evidence is given as to the influence of the Homerton, Deptford, and Stockwell Hospitals when in use for small-pox. The fact that large small-pox hospitals, containing a considerable proportion of acute cases, are centres of infection, is thus, after full consideration, freely assented to; but the question remains—Are they a source of danger only in their incidents, or are they such *per se*, by disseminating infection through the atmosphere? We have dealt fully with Mr. POWER'S views as to this, but we would here further remark that although the "gradation of hospital influence from centre to periphery" might, as the Commissioners point out, result equally whether the influence for harm were brought about by the conveyance of infection by human movements or by atmospheric dissemination, yet the hypothesis of personal communication does not easily explain the following facts: (1) "That the houses on the lines of human intercourse have not suffered more than—or even as much as—other parts of the same neighbourhood"; (2) "the sudden and simultaneous attack of a considerable proportion of susceptible people living round the hospital, and having no discernible relations with the hospital or with each other"; and (3) the striking "constancy in the gradations of incidence upon the several divisions of the special area" round the Fulham Hospital, during five separate and distinct periods when the buildings were in use for small-pox patients.. On the other hand, however, all these, in addition to other obscure points, are explicable on the hypothesis of the conveyance of infection through the atmosphere. Indeed, in dealing with this matter we seem to detect a divided opinion on the part of the Commissioners. If they were unanimously of opinion that personal communication by nurses, ambulances, &c., had really led to the spread of disease around Fulham, the recommendations which they make as to small-pox would hardly have been based, as they appear to be, on the operation of an atmospheric dissemination of infection. One proposal as to small-pox is that the number of beds for patients suffering from this disease in any one hospital ought to be limited to "thirty or forty," and it is added that with this limitation "the evil arising from atmospheric diffusion will be reduced within very narrow limits."

With regard to fever hospitals, the Commissioners believe that when well conducted they involve no appreciable risk to the neighbourhoods in which they are situated, and hence they propose that the existing hospitals belonging to the Metropolitan Asylums Board should be retained for the treatment of the infectious fevers other than small-pox, the

fever convalescents being removed to country hospitals. As regards small-pox patients, it is proposed that all the mild cases and all the convalescents should also be removed to hospitals in the country; and, further, that some of the less severe cases should be treated in floating hospitals or in buildings on the banks of the Thames. But they believe that some provision must be made in London itself for the more severe cases, and hence they suggest that on each of the hospital sites belonging to the Metropolitan Asylums Board there should be a detached small-pox hospital for some thirty or forty patients. At first sight, it might appear that under such a course of action our measures of defence against small-pox would turn out to be less effective than those available in the case of other infectious diseases. This, however, is not so. In vaccination we possess a means of prevention against small-pox which as yet has no counterpart as regards any other of the specific fevers; a point fully recognised by the Commissioners, who declare that if careful vaccination were general the liability of the metropolis to serious epidemics of this disease would cease.

Hitherto it has been the practice to use the existing hospitals for patients from any part of the metropolis, an arrangement which has called forth strong protests from the inhabitants of the districts into which outside cases of infection were thus imported. The Commissioners, having regard to the future, condemn this arrangement, for they say, "It is most important to avoid as far as possible the injustice of transferring, in any case, the disease of one populous district to another." And they go on to consider how London may best be divided into hospital districts. That each parish should become a hospital centre, and manage its own affairs as regards isolation, is at once set aside, on the ground that this would necessitate the sudden establishment, on the occasion of every great epidemic, of thirty or forty institutions, some of which would certainly be mismanaged and become effective foci of infection. But it is thought that with a more effective method of election, and with fresh powers as to the purchase and retention of sites, the Metropolitan Asylums Board might be the Isolation Authority for all classes, and that London might under this arrangement be divided into some eight independent hospital districts, each dealing with its own infectious sick, much in the manner already indicated. This arrangement would still leave a considerable aggregation of fever patients at each centre, and it would concentrate together, in a manner heretofore not contemplated, a number of the more severe of the acute cases of small-pox. These points are by no means unimportant, and we hope shortly to revert to them, especially in connexion with a proposal by Dr. BURDON SANDERSON, F.R.S., as to specially constructed infectious hospitals. According to the plan proposed, the hospital ventilation would be effected in such a way as to secure that all air should be forcibly drawn into the wards, and that it should be subsequently discharged into a chamber where it could be subjected to a temperature sufficient to destroy all contagion. A plan and description of such a hospital, as also Dr. THORNE THORNE'S General Report on the Use and Influence of Hospitals for Infectious Diseases, Mr. W. H. POWER'S Report on the Influence of the Fulham Small-pox Hospital, Mr. SHIRLEY MURPHY'S Report on the Influence of the London Fever Hospital, and several other valuable documents, go to form an important Appendix to the Report of the Commission.

THE nature of Croupous Pneumonia has always been a fertile field for speculation. The opinion that it is a simple inflammation due to a simple cause long received unquestioning acceptance, until points of resemblance between pneumonia and an acute specific disease led to more careful study of its conditions of origin. It is still to these that the attention of physicians is chiefly turned. Pathologists, it is true, are seeking for its associated bacterial organisms, and we lately referred to the important observations of FRIEDLANDER on this subject; but bacterial pathology is still in too early a stage to permit much weight to be placed on the discovery of organisms in association with acute inflammation as evidence of a necessary causal relation. But the etiological facts, if well observed, have a value which no theory can shake, for they must be embraced by it as a necessary condition for its acceptance.

Many facts have lately been adduced in support of the opinion that croupous inflammation of the lung is but the local expression of a general disease, and the evidence in favour of this view has been ably summarised by an American physician, Dr. E. SANDERS, in the *New York Archives of Medicine*. The most weighty evidence is, of course, that furnished by the analogies to which we have referred, but the occasional epidemic character of outbreaks of pneumonia is an etiological point of considerable weight in support of the theory. It is necessary, however, in order to establish the specific pathology, to disprove the current opinion that croupous pneumonia may result from mere exposure to cold. Some have, indeed, been content to overcome the difficulty by the admission that there are two forms of croupous pneumonia—one due to cold, and the other a specific disease. But the sporadic cases which are usually referred to cold are precisely those which present that resemblance to acute general diseases which still constitutes perhaps the strongest part of the argument for the specific nature of the malady. Accordingly, most of the advocates of the latter view have felt that, to establish their argument, they must disestablish the current theory and disprove the dependence of croupous pneumonia on exposure to cold.

The task is one of no small difficulty, and from isolated observations perhaps impossible. Attention has therefore been turned to the comparison of pneumonia with the meteorological influences. It seems well established that the disease does not coincide in the time of its occurrence with the lowest annual cold. It is not a disease of winter, but of spring. Some facts corroborating this opinion have been lately collected in the *Revue des Sciences Médicales*. In the three great hospitals of Vienna, between 1866 and 1876, 11,442 cases of pneumonia were treated—8247 men and 3195 women. The largest number of cases were admitted in the month of April, the next largest in the month of March, and next in the month of May. KÖHNHORN observed in the barracks at Weser 300 cases of pneumonia in the course of eight years, and found that the number of cases in the three months of March, April, and May was four times as great as in the months of September, October, and November.

WARFWINGE, in Stockholm, observed a maximum in the month of May.

But we can scarcely admit the validity of the assumption that because pneumonia does not coincide in prevalence with the lowest temperature it is therefore not due to exposure to cold. The prevalence in Vienna was compared by BIACH with the meteorological report, and three conditions seemed to coincide with the disease: a sudden fall in atmospheric pressure, a low temperature, and sudden changes in temperature. A similar comparison has been made by MASSON with regard to 400 cases of pneumonia occurring at Berne and Neufchâtel; and he found that pneumonia was most frequent when the temperature of the air was low and its humidity slight; and a comparison of the conditions on the day before the onset of each case showed with great frequency a sudden fall in both temperature and atmospheric pressure. On the other hand, KÖHNHORN failed to observe any relation between his cases and the temperature; but his data appear more open to objection than the others to which we have referred.

The evidence afforded by epidemics of pneumonia would be more conclusive if such epidemics were less rare. Nevertheless they are of great interest, and certainly deserve most careful study. Some of them are described by Dr. STURGES in his work on Pneumonia, and several others have been lately recorded. HOLWEDE and MÜNNICK observed an outbreak of fifteen cases in a small village (Ober-Sikle), containing only 400 inhabitants, and in some instances as many as three persons were affected in one house. At the same time other neighbouring villages, exposed to the same meteorological influences, and in the same geological conditions, were free from the disease. In the village of Becherbach, with 460 inhabitants, BUTRY observed as many as twenty cases in the course of a few weeks, and no less than nine were fatal. The cases occurred in a small number of families, which were so grouped around those first attacked as to favour the idea of a spread by infection. In most of the cases the prostration was great; in several there were cerebral symptoms, and in five there was jaundice. In seven the apex of the lung was invaded; in five the pneumonia was double; in three there was secondary pleurisy. The spleen was not enlarged in any case. KERSCHENSTEINER observed 161 cases of croupous pneumonia in a prison at Amberg (Oberpfalz), during the four months January to May. The *materies morbi* appeared to him to be endemic and not transportable. In a district of Norway containing 6000 persons LÖBERG observed sixty-three cases of pneumonia in 1879, and twelve occurred in a limited region containing only 200 persons. The cases were grouped, several occurring in the same house. PENKERT has recorded an epidemic of forty-two cases, in which he believed himself able to trace an infection from person to person, and JELLEY observed a wife to contract pneumonia from her husband, and to communicate it in turn to a sister who nursed her. Similar cases have been noted by WYMAN. No instance, however, is more remarkable than that published in our columns by Dr. DALY a year ago, in which six members of one family were affected in the course of three weeks. The rarity and striking nature of these facts, however, may well suggest caution in reasoning from them to the familiar sporadic form of the disease.

Attempts have been made to ascertain whether the contagiousness of pneumonia can be proved by experiments on animals. KÜHN inoculated seventeen animals with the sputum of a case of "endemic pneumonia." Of the rabbits, two died on the first two days with symptoms of collapse, but in six others fever followed the inoculation, and presented critical oscillations at the end of the fifth or sixth day. Diarrhœa and prostration accompanied the pyrexia. The animals killed between the sixth and tenth day showed pleurisy and hepatisation of the lung, lobar or lobular. Five recovered. KÜHN, perhaps too hastily, regards his results as affording evidence of the specificity of croupous pneumonia.

Those physicians who find, with LEICHTENSTERN, the contrast in etiological conditions between the sporadic and epidemic forms of pneumonia too striking to be ignored, and ground for a division of croupous pneumonia into two classes, have endeavoured to establish a clinical distinction between the two. SCARPARI, for example, has lately emphasised the asthenic character of the epidemic form, its association with jaundice, with yellowish fibrinous pleural exudation, the absence of resolution, and the occurrence of changes in liver and spleen similar to those which are met with in acute specific diseases. LÖBERG observed the frequency with which several initial rigors marked the onset of his cases, sometimes preceded, for three or four days, by the symptoms of catarrhal fever, and the frequency of jaundice, but he failed to find enlargement of the spleen. Several observers have noted the tardiness of resolution and the frequency with which the apex of the lung suffered. KÖHNHORN, on the other hand, at Weser, observed splenic enlargement to be the rule. It is very desirable that the actual weight of the organ should be noted in all fatal cases.

THE current number of the *Westminster Review* contains an article on River Pollution, by Mr. URQUHART A. FORBES, which possesses interest for many of our readers. Mr. FORBES has given us a vivid sketch of the still modern history of legislation in regard to the pollution of rivers, and drawn conclusions which are peculiarly apposite just now, when we all hope that further legislation is impending.

The history may be said to begin in 1848, when sewer-drainage was first enforced by Act of Parliament. The new system was extensively adopted, and it was soon found that while it did much good to the land, it did very great harm to the rivers. As London and many other towns are supplied with water from these rivers, complaints soon arose, which were intensified by the experiences of the cholera epidemics of 1854 in St. James's, and of 1866 in East London. In 1865 a Royal Commission, consisting of Messrs. RAWLINSON, HARRISON, and WAY, was appointed to inquire into the whole subject. They published three Reports, the last in 1867. In 1868 another Commission, consisting of Sir WILLIAM DENISON, Professor FRANKLAND, and Mr. J. C. MORTON, continued and extended greatly the labours of the first. The sixth and final Report of this second Commission appeared in 1874, so that the Commissions sat altogether for a period of nine years, in which time they issued no less than sixteen folio blue-books. Most valuable information respecting pollution by sewage, and by the refuse of factories, was collected. Dr. FRANKLAND in

particular, who had introduced new methods of analysis and shown the fallacy of some old ones, performed countless analyses and made experiments on purification which have the highest value, and altogether did more than any other observer in the same field, before or after. His labours resulted in the suggestion of certain standards of purity, which, it was contended, might, without undue severity, be imposed on towns and manufacturers. The whole inquiry, from first to last, cost an enormous sum of money, and is a model of patient scientific investigation.

With these ample materials in hand Mr. DISRAELI'S Government produced in 1875 a short and feeble Bill of the permissive order, in which most of the recommendations of the Commissions were completely ignored. This Bill fell through, and in the following year a second and feebler one was introduced by Mr. SCLATER BOOTH. After additional emasculation both in Commons and Lords, this second measure received the Royal assent on August 15th, 1876, and is now known as the Rivers Pollution Prevention Act, 1876. We expressed a strong opinion at the time of the inefficiency of the new measure, pointed out that it contained every element of vagueness and weakness that such an Act could contain, and predicted that it would prove a dead letter. It has long been known that this prediction has been fulfilled to the letter. Mr. FORBES tells the story so graphically, that we prefer to use his words:—

"The Rivers Pollution Prevention Act, 1876, resembles the celebrated picture told of in the 'Vicar of Wakefield,' which though it pleased Dr. Primrose and his family highly, was rendered worse than useless by the fact that it was of such a great size that it could never be got out of the kitchen where, for convenience sake, it had been painted. It is admitted to be an admirable statute, save for one fault—it cannot be put into operation. It applies to England, Scotland, and Ireland; it, for the first time in the history of legislation, recognises pollution as an offence, and punishes it by a fine of £50 a day; and it prohibits the putting of solid matter, sewage pollutions, and mining and manufacturing pollutions into rivers, streams, canals, lakes, and water-courses, other than water-courses at the passing of this Act, mainly used as sewers, and emptying directly into the sea, or tidal waters which have not been determined to be streams within the meaning of this Act by order of the Local Government Board. Yet in spite of all these merits, the few instances in which it has been attempted to enforce it since it came into force in August, 1877, have entirely failed. The reasons of this failure were made clearly manifest by Mr. Cresswell in his speech on the necessity of amending the Act at the Conference of the Society of Arts on Public Health in 1880. It is due in the first instance to the fact that it makes no satisfactory provision for the payment of costs, and hence the expenses of bringing it to bear on offenders have been so heavy as to be almost prohibitive. Secondly, like all similar enactments on the subject, it throws the onus of beginning to institute proceedings on individuals who feel themselves aggrieved by pollutions, and further requires them to act only through the local sanitary authorities, who, as has been so frequently pointed out, are the chief offenders."

Several other fatal defects are pointed out by Mr. FORBES, and we could extend the list in many ways; but enough has been said to show how perfect an example of weak and tinkering legislation the Act of 1876 was. We can only conclude with expressing an ardent hope that the result of the Royal Commission, whose labours will recommence before these words are printed, will be not only to relieve Londoners and travellers on and by the Thames from the hideous nuisance from which they now suffer, but also to pave the way for an Act of Parliament which shall be in truth, and not merely in name, a Rivers Pollution Prevention Act.

IT would be satisfactory to know that the Government intends to bring in a measure founded on the recommendations of the Royal Commissioners. We venture to hope that a question will be put to Mr. MUNDELLA which will elicit information that is anxiously awaited by the profession. We do not, of course, expect any immediate action by the Government. The present session is entirely exceptional in its character and object. It is a session practically of only one branch of the Legislature, and that for a definite purpose. The purpose in our estimate is a great one, and justifies the calling of the House of Commons together that it may exclusively be carried out. In common with other members of the Press, we have been struck of late years with the inefficiency of the House of Commons as a business instrument. When surgeons have an inefficient instrument they sharpen it. And no different device will save the reputation of the House of Commons. Apart from all political theories and partialities, there are great acts of legislation urgently demanded, which it is simply hopeless to expect so long as every group of agitators can waste week after week in noisy and unpractical declamation. We devoutly wish success to the new Rules of Procedure so far as they are calculated to make the House of Commons do more and talk less, for the disproportion between its loquacity and its acts has become a scandal and a pain to all earnest men. But though Mr. MUNDELLA may scarcely be expected to lay a Bill on the table, he would do great service by intimating at once and decisively that he meant to deal with the amendment of the Medical Acts in the direction of the report of the Commissioners. It is evident that things cannot continue as they are. There is not a medical or surgical corporation that is not perplexed with "thoughts of change." All the medical students of the period are similarly affected, and it would be the greatest boon to them to substitute the existing and fragmentary examinations by other and complete examinations. Students at present are harassed and hampered by the defects and differences of the examining boards. When they do get a diploma they find out that it is only half a diploma, and very likely that it is disparaged and aspersed by those who represent other and rival diploma-granting bodies. Our recent numbers have contained the evidence of the gross inequality of the examinations, in different parts of the kingdom, that should be practically the same. We shall soon deal with other parts of the evidence having reference to the inefficiency of the Medical Council. An educationist and a reformer like Mr. MUNDELLA cannot fail to see in this evidence, and in the report based on it, the necessity for legislation, and we venture to hope for an assurance that legislation will be undertaken in an earnest spirit.

NOTICE is given in the *London Gazette* of the 20th inst. that vessels arriving in Italy from Florida or Texas, U.S., will be regarded as infected with yellow fever and subjected to quarantine.

Annotations.

"Ne quid nimis."

ARMY MEDICAL SERVICE IN EGYPT.

WE are glad to learn that Mr. Childers has appointed a committee to inquire into the truth of the statements which have been made respecting the alleged shortcomings of the Army Medical Service in Egypt. It will consist of the following members:—The Earl of Morley, Under Secretary of State for War, Chairman; Admiral Sir W. R. Mends, K.C.B., Director of Transports; Major-General Hawley, C.B, Deputy Adjutant-General; Major-General Sir Evelyn Wood, C.B., K.C.B., K.C.M.G.; Dr. T. Crawford, Director-General, A.M.D.; Sir W. MacCormac, M.D., and G. Lawson, Esq., Assistant Director of Supplies and Transports. The composition of the committee is a sufficient guarantee that the whole question will be carefully, honestly, and intelligently considered, and we have no doubt that valuable suggestions will be made with a view to render the service more efficient, and to remedy any defects in its organisation which may be brought to light.

EDUCATION BASED ON THE LAWS OF HEREDITY.

ATTENTION has been recently directed—notably in a little book entitled "Youth; its Care and Culture"—to the wisdom of basing education on the laws of heredity. This is something more than a mere recognition of what are called "physiological principles." If that term, as commonly used and understood, expressed all it actually implies, there would be no need to amplify its import. Mind is brain-function, just as locomotion is one form of muscle-function. The brain, when it acts, thinks and reasons, and judges and forms purposes. As the size, weight, form, and development of the bony skeleton, with its muscular apparatus, determine the limits and nature of physical power and activity, so do the size, weight, form, and development of the brain, with its apparatus of sense-organs, determine the limits and nature of intellectual power and activity; and as the personal characteristics of the physique are in great part inherited, in like manner the personal characteristics of mind are handed down from parent to child, so that the mental and moral qualities offering themselves for culture by processes which are, in the true sense of the word, *e-ducationary* in any individual, are the sum, or the resultant, of the aggregate qualities of the two parents, *plus* the influence of congenital conditions and immediately surrounding circumstances. It is essential to recognise this initial fact, and so to order and apply the processes of education as to develop the good and repress the evil elements in the inherited character. Education ought to be individual and to comprehend a complete system of influences and processes adapted to the cultivation of the physical and mental nature in its concrete form and potentiality. There can be no greater or more ignorant blunder than to regard education as *teaching*. "Training" is a better term to use than teaching, but education in its full and practical sense means much more than both the ideas indicated by these two terms; it implies *improvement*, and "improvement, as applied to the compound organism, the physical and mental nature of man, must include the essential processes of culture, planting or grafting, uprooting or pruning, and growth-stimulation and training. Unless this threefold purpose of education—employing that term in its comprehensive and only true sense—is fulfilled, genuine improvement is impossible, whether consciousness strive to improve self, or others labour to nurture and train it. This is true of both body and mind, subject to the mutual relations which exist between these two parts of man's nature, if, indeed, they are separate. Every child born into the world is charged with potential energies that need to be stimulated, and with some which, in the interests of individual happiness and social expediency, it is necessary to eliminate, or, at least, repress." This being so, two consequences must be seen to ensue. First, to be really effectual, each child in a school or family should be trained and taught in a manner and upon principles peculiar to himself or herself, and not by a common method or to a common pattern. Second, the surroundings of child-life, the influences brought to bear upon it, the tasks imposed, the exercises body and mind are required to perform, the food with which they are severally fed, and the *régime* to which they are subjected, ought to be carefully selected and graduated to the individual nature and its special needs. If only a tithe of the truth about education were clearly understood, it would be seen that the care of the young is not only a responsible duty, but one which calls for special knowledge, rare sagacity, and exceptional skill.

THE MILK OF INTEMPERATE MOTHERS.

LAST week we received a letter from a correspondent, who stated that at a "blue ribbon" meeting (for women only), a working man's wife said that she was present at a similar assembly a short time before, in the course of which a physician, by way of proving to the nursing mothers present the injurious effect of intemperance on their offspring, left the room and presently returned with a sample of milk drawn from the breast of a drunken woman, to which he then applied a light, the result being that the milk burnt for five seconds. Our correspondent, who signed herself "Incredulous," asked if this were possible, and although we had no hesitation in answering in the negative, the question raises several very interesting issues. First, as to the presence or absence of alcohol in normal human milk. It is of course well known that koumiss is an alcoholic liquor prepared from milk by vinous fermentation of the lactose; the change is a slow one, lactose being of all sugars the least susceptible of fermentation. In the milk of the cow and ass, even when freshly drawn, alcohol was found by Béchamp, the alcohol increasing if the milk was allowed to set. This of course suggests the same origin for the alcohol as in the case of koumiss. With regard to human milk, the presence of alcohol, even if found, would suggest a similar explanation, but its presence has never been proved. Still, the wife of the working man is not the first person who has made assertions as to the alcoholic milk of alcoholic mothers. On examination, however, these assertions are seen to be founded not on chemical analysis, but on statements as to the effects of the milk on the infant. In an adult these would of course consist of exhilaration, followed by swimming eyes, inarticulate speech, unsteady gait, "dyskinesia" (uterine, no doubt, in female children), and even inability to stand. We may observe many, if not all, of these symptoms in most infants at the breast; and, indeed, in this way the inability to recognise one's own father might be taken as evidence of double vision. Is, then, the whole infant population to be regarded as more or less permanently drunk? Again, evidence may be obtained from the remoter effects of alcohol. We have heard a story of a child who died of cirrhosis of the liver from the prolonged exhibition of steel wine; but we may safely affirm that if even a trace of the alcohol constantly imbibed by a large proportion of nursing mothers were to find its way into their milk, specimens of infantile cirrhosis would be far from rare. On the other hand, there is no doubt that some of the alcohol of alcoholic mothers not unfrequently finds its way into the

system of their infants by a more direct route than the milk. Setting aside, therefore, the question of alcoholic human milk as contrary to fact, one question still remains—namely, that of the general effects of alcoholic drinks on the milk of nursing women. To this question no short answer can be given. It may be stated at once, that the diet which ensures the best state of health and nutrition also ensures the best milk, but that no hard-and-fast rule can be laid down on the subject. Overfeeding, as well as underfeeding, will often impair both the quality and quantity of the milk. It is, however, as in so many other questions, highly unscientific to lump all alcoholic drinks together, seeing that in those most generally useful, the alcohol is by no means the principal ingredient. To put gin and mild beer and claret together is to collect strange companions, who have, indeed, a common property, but little more. We are, however, within the mark in saying that, special medicinal questions apart, no nursing woman should drink spirits; that the less stimulant she can take (consistantly with good health) the better; but it is no less true that in mild malt liquors, and especially in sound porter and stout apparently from the special preparation of the malt), we have a very simple and excellent stimulant to the lacteal secretion in many cases where it flags, and even in some cases where malt alone or other stimulants have failed. Of the impoverishment of the milk of women whose health is impaired by drinking there can be no reasonable doubt, and too much can hardly be stated in this respect. We quite agree with the blue ribbon orator so far as this, that if all nursing mothers were teetotallers it would be far better for the totality of British babies. In saying this, however, we must add that some infants would, in our opinion, be the worse; but that, on the principle of "the greatest good for the greatest number," more would be benefited than injured. If only those nursing mothers took stimulants whose health was really improved by them, it would be better still. There are facts which seem to show that alcoholism produces in some women a functional or temporary sterility. On this question, being beside our present subject, and also as not unlikely to serve as an incentive, or at least an excuse, for intemperance, we will not enter. Is it not somewhat of an irony of fate that the teetotal cow and ass should produce alcoholic milk, while the alcoholic human female produces none?

HÆMORRHAGE AFTER EXCISION OF THE TONSIL.

THE removal of an hypertrophied tonsil is a frequent and simple surgical operation, in connexion with which any complication is so infrequent as to be unheeded by many operators. Experience abundantly proves, however, that it is not unattended with danger from hæmorrhage, one of the most serious features of which is that it may not be primary but intermediary, or what is usually spoken of incorrectly as "secondary." There may be only the usual slight amount of hæmorrhage at the time, and then some hours later a profuse flow of blood occurs. This fact it is which gives additional import to the complication. Dr. Lefferts, of New York, has recently drawn attention to this subject, and has recorded cases in which the bleeding has been profuse, and discussed the appropriate treatment. In this country, we believe it is a not infrequent plan to give every patient an astringent powder to be moistened with water and introduced into the back of the throat should bleeding come on. Dr. Weir has recently recorded a case of this intermediary hæmorrhage, which illustrates well one cause of it, and the explanation of its mode of occurrence. One tonsil of a young man was removed with a guillotine; there was slight hæmorrhage at the time, but several hours afterwards, severe loss of blood—estimated at a pint—ensued, which was controlled by the application of persulphate of iron and by pressure; the bleeding recurred twice subsequently. When Dr. Weir saw the patient he found that the bleeding vessel was an artery in the anterior pillar of the fauces. The vessels of the tonsils are small and lie in soft tissue, which readily permits of their natural closure when severed, and the various movements of the throat do not of themselves disturb the wounded vessels. Not so is it with the palatine arteries; they are, in the first place, larger, and, as they lie in the muscular tissue of the palate, when wounded they are constantly exposed to disturbance from the contractions of the palate muscles in deglutition. If one of these vessels be wounded then, in the operation of excising the tonsil, not only is the hæmorrhage freer than from the tonsillar vessels, but there is a great tendency to recurrent bleeding from the constant movements to which the wounded vessel is exposed.

THE MUNICH ELECTRICAL EXHIBITION.

IN addition to a varied display of electricity as applied to technical uses, there is a special branch of the above exhibition devoted to the illustration of the employment of this force in theoretical and practical medicine. In the descriptive remarks which Dr. Stintzing has published on the subject, he alludes to the value of electricity as an exciting medium when judiciously applied to various parts of the human organism, and remarks that electro-physiology has done much to increase our knowledge of the properties and functions of the nervous system, the muscles, the glands, &c. Another important branch of medical science connected with electricity is the diagnosis of certain diseases by means of electrical tests applied to the living body; on which subject he further remarks that physiology teaches us the laws as to convulsive motions, according to which the nerves and muscles are affected by the exciting power of electricity. For instance, if an electrical current (whether constant or interrupted) of a given strength be applied to a nerve, the muscles with which it acts are excited and become contracted according to fixed laws. In these involuntary reactions of the organs of motion upon the electrical current it makes a difference whether the latter passes through the nerves in an ascending or in a descending direction, and whether the action of the positive or negative pole preponderates. When the body is diseased, these physiological laws are subject to changes, and by carefully noting the deviations from the general rules which may be observed in the application of the electrical current in different ways to sick persons, conclusions may be drawn of practical value in the diagnosis and prognosis of such cases and in the regulation of the most suitable form of treatment for them. Electro-diagnosis and electro-therapeutics go hand-in-hand, and the exhibits at Munich affecting medical electricity illustrate both subjects; the appliances connected with the former being of course the more complicated. The Munich Medical and Clinical Institute and various manufacturing firms exhibit instruments of great exactness for ascertaining and regulating the force of the electrical current. A great variety of instruments and appliances of a portable form, suitable for general use by medical men, are also exhibited, including batteries, communicators, wires, &c., constructed with special reference to the different models which the various parts of the body require for the successful application of the electrical currents. For electro-therapeutical purposes the accurate measurement of the strength of the electrical current is indispensable, and the simple yet effective galvanometers for this purpose, made in two sizes by Dr. Edelmann of Munich, at the suggestion of Professor von Ziemssen, are highly spoken of. In contrast with the use of electricity, as applied by means of batteries and inductive appliances, the employment of electricity obtained by friction has been specially recommended of late by

Dr. Stein of Frankfürt, and various instruments &c. required for the application of this method are exhibited by Messrs. Albert, of that city. The photographs illustrative of the effects of electricity upon the nerves and muscles, and other representations showing the muscles, or groups of muscles, most easily affected by the electrical current, are interesting adjuncts from a medical point of view. Dr. Stintzing also refers to an electro-endoscopic apparatus, which is applicable to diagnostic purposes. It is intended for the partial illumination, by electrical means, of the ear, nose, jaws, and other portions of the human body. In the same category mention is made of two small endoscopic instruments exhibited by Dr. Michael, of Hamburg, in which phosphorescent substances are subjected to the influence of an electrical discharge.

ROYAL MEDICAL AND CHIRURGICAL SOCIETY.

THE present Council of this old-established Society, under the guidance of its President, Mr. Marshall, and the Hon. Secretaries, Dr. R. Thompson and Mr. B. Hill, have been carrying out certain "innovations," which, although, as the President stated, of comparatively minor importance, are steps in the right direction to ensure a high standard of merit in the papers read before the Society, as well as to enhance the value of the debates arising upon them. One of these innovations is the printing of the abstracts of the papers three or four days before the meeting, so as to enable intending speakers to obtain copies of these abstracts for private perusal and study. In this way it is hoped that the speeches will be more matured and more distinct contributions to knowledge, adding greatly to the importance of the discussions. Authors of papers are also to be allowed, when deemed necessary, to read their own papers. Hitherto this task has devolved upon the Hon. Secretaries, and we think the change one which will greatly facilitate the proceedings of the Society. Reports of the discussions are also to be printed in the Society's Proceedings—a step which will, it is thought, and rightly, cause this publication to be more read than it is at present. Another feature of the meetings is the addition of demonstrations of subjects of scientific interest, new inventions of practical and scientific value, new subjects in anatomy and pathology, &c., all with a view to render the meetings more attractive and useful. In each and all of these directions we think the Council has acted most wisely, and we trust that the communications made to the Society will maintain the high reputation it has already gained, and increase the attendance at the meetings. It may be added that during the recess considerable structural alterations have been made in the Society's rooms, and a great improvement has been effected in the lighting of the main hall.

A NEW VEGETABLE STYPTIC.

A RECENT number of the *Neue Freie Presse* states that during the French expedition to Mexico a plant was discovered, called by the natives by a name which may be rendered as "Fowlwort" (Tradescantia erecta, Jacq.), which has the property, when chewed or crushed, of stopping any hæmorrhage. A specimen planted in 1867 by the discoverer, in his garden at Versailles, has not only flourished, but flowered and fruited, without having its peculiar properties as yet appreciably diminished. Although no exotic, or remarkable for particular beauty of bloom, it, nevertheless, deserves a wider extension on account of its valuable properties, especially as its acclimatisation may be regarded as having been fully established. Its action exceeds that of all styptics as yet known, as, for example, perchloride of iron, and it can, moreover, be very cheaply procured.

THE DANGERS ATTENDING SHAMPOOING.

RECENT and unsatisfactory experience in one or two West-End hair-cutting saloons leads us to inquire whether sufficient care has been bestowed on the sanitary management of the shampooing contrivances. Those persons who avail themselves of the very refreshing pleasures of a "shampoo" must, however, have noticed that they are compelled to bend over, and bring their faces in close proximity with, the hole in the centre of the huge basin used for this purpose. If they watch the soapsuds that form round this hole before any large volume of water is allowed to flow, they may perceive the air coming up the pipe; for it inflates the soap and forms a large bubble that bursts close under them. Whatever may be within, it is too near to avoid breathing its contents. Nor does the absence of any suspicious odour inspire a sense of security; for it is very evident that even a strong whiff of sewer gas would be lost in the scent that perfumes the soap and surrounding atmosphere. If therefore the pipes attached to the basins communicate direct with the house-drains and the sewer, there is surely some danger that the atmosphere breathed within a couple of inches of the aperture may carry, disguised under the fragrancy of the rose or jasmin, the virus of disease. In one of the most celebrated West-End houses we noted that the pipes from the shampooing basins all led on to the roof of an outhouse, and there the soapsuds and water travelled some three or four yards in the open air before reaching the water-spout that conveyed them to the sewer. A back current could therefore only bring in air from the roof—that is, air as pure as any to be had in London. But in another house nearly as celebrated the pipe from under the basins ran direct to the drains. There was no S-trap visible, and apparently no intercepting ventilation. The basins had, in fact, all the appearance of so many sewer mouths, ventilating the sewer-gas into the faces of the customers as they leaned over the aperture. Even a syphon in such cases is not, we maintain, a sufficient protection; the constant flow of water, the difference of temperature between the hot and cold water, and the varying degrees of density of the water through the presence in small or larger quantities of soap, oil, &c.,—all these circumstances must so affect the pressure and tension of the air within the pipes as to produce suction, up currents, and syphonage. Consequently it is indispensable that all the pipes conveying the waste from hairdressers' saloons should empty in the open air over a gully-trap or an interceptor, and should not have any direct connexion with either the house drains or the public sewer.

SUMMER DIARRHŒA IN 1882.

JUDGED by the figures published from time to time in the Registrar-General's weekly return for twenty-eight of the largest English towns, with an aggregate population of about eight million and a half of persons, it is evident that the fatality of diarrhœa during the past summer, although slightly higher than it was last year, was again considerably below the average. In London the annual death-rate from this disease showed a larger proportional decline than in the provincial towns, and did not exceed 1·5 per 1000, against 3·2 and 2·5 in the summers of 1880 and 1881. The rates in the large provincial towns showed the same, a similar variation which should throw light upon the true causation of this disease, but which has not yet led to its satisfactory explanation. During the thirteen weeks ending September 30th last the death-rate attributed to diarrhœa did not exceed 0·9 in Halifax, 1·0 in Bristol and Derby, and 1·3 in Plymouth and Huddersfield, whereas the highest rates in the other provincial towns were 4·0 in Leeds, 5·7 in Leicester, 5·8 in Hull, and 6·0 in Preston. All these towns are old offenders in respect of infantile diarrhœa, and

of infant mortality generally. It is also noticeable that while, as we have stated, the death-rate from diarrhœa last quarter in these large towns showed a general increase upon that in the corresponding period of 1881, the rate of increase varied in a marked manner; indeed, in several of the towns the rate showed a decline. All these facts point conclusively to controlling influences other than meteorological. It may be hoped that the Local Government inquiry on this subject, now being conducted by Dr. Ballard, will throw satisfactory light upon this much discussed but yet unsolved problem.

THE LATE PROFESSOR BALFOUR.

AN influential meeting was held on Saturday last in the Lecture room of Comparative Anatomy at the New Museum, Cambridge, to consider the best mode of establishing in the University a memorial of the late Professor Balfour. The Vice-chancellor presided, and the meeting was attended by Professor Huxley, Messrs. H. Smith, Lankester, Foster, Paget, Humphry, Newton, and others. Great regret at Professor Balfour's untimely close of a career so full of promise was expressed by every speaker. Professor Paget proposed the first resolution, that a memorial of Professor Balfour be established in the University of Cambridge, which was seconded by Mr. H. Smith. In supporting this resolution Mr. Adam Sedgwick instanced as proof of the attractive address and teaching of Professor Balfour that his class which at first only consisted of ten or twelve students, had in the course of seven years increased to ninety. Professor Huxley then proposed that the memorial take the form of a fund to be called the Balfour Fund for the promotion of research in biology and especially animal morphology. Professor Newton proposed, and it was unanimously agreed upon, that the proceeds of the fund should be applied to establish a studentship, the holder of which shall devote himself to original research in biology, especially animal morphology, and further, that the fund should supply occasional grants of money for the furtherance of original research in the same subjects. Professor Foster finally proposed that the studentship should be endowed with £200 per annum, and that it should *not* be given away by competitive examination. It was stated at the meeting that £3000 had been subscribed by the family of Mr. Balfour, and that £1000 which he had himself bequeathed to Professor Foster would be expended in promoting the objects aimed at in the memorial.

TUBERCLE OF THE CHOROID.

AN interesting discussion took place at the Ophthalmological Society on the 12th inst. upon the significance of choroidal tubercle. Examples of the disease were related by Drs. Mackenzie, Warner, and Brailey, and the discussion turned chiefly upon a point raised in the communication of the second-named gentleman—namely, whether the choroidal affection were not more frequently met with as a part of general tuberculosis than in association with tubercular meningitis simply. The question produced some slight divergence of opinion,—such experienced observers as Dr. Baxter, Mr. Hulke, and Mr. B. Carter stating that tubercle of the choroid was of extreme rarity in cases of meningitis, and therefore the inference is that much reliance cannot be placed upon it in determining a diagnosis, or rather that its absence proves nothing in the exclusion of a diagnosis of tubercular meningitis. On the other hand, Dr. Barlow mentioned that he had detected it in as many as twenty cases, verified on post-mortem examination. After all, the issue seems to have been a narrow one; for it must be borne in mind that in the vast majority of cases of tubercular meningitis there is tuberculosis of other viscera, and that the meningeal affection is as much a part of the general dissemination of tubercle as is the choroidal. At the same time this fact is plain, that tuberculosis of the choroid no more depends upon tuberculosis of the pia mater than this latter does upon tuberculosis of any other organ. Dr. Sansom's contribution to the discussion was instructive. He cited a case with symptoms of meningitis in which he had given a most unfavourable prognosis because ophthalmoscopic examination revealed choroidal tubercle. The event proved one of three things: either that tubercular meningitis is not necessarily lethal, or that tubercle may exist in the choroid without being present elsewhere to any grave extent, or that the ophthalmoscopic diagnosis of choroidal tubercle is open to fallacy. Which of these interpretations is the most likely must remain undecided, but it is to be regretted that Dr. Sansom had no opportunity of again examining the eye after the recovery of the patient from the meningitis. The attention thus drawn to the subject should encourage investigation into the occurrence of choroidal tubercle, not only as detected by the ophthalmoscope, but as found in post-mortem examination of all cases of tuberculosis.

SIR THOMAS WATSON, BART.

THE whole profession will learn with deep concern that the health of this revered physician has during the last few days been a source of anxiety to his family and friends. He had for some weeks past been staying with his son at Reigate. On Sunday last, although now in his ninety-first year, he was in his usual good health and attended the morning service. On attempting to rise from his chair after lunch he suddenly inclined towards the left side, and would have fallen on the floor if he had not been supported by his son. He afterwards took a short walk in the garden, but there was an evident weakness of the left leg, and this continued to such a degree that he is now unable to walk without assistance. There is no appreciable loss of power in the arm, but the tongue when protruded deviates slightly to the left. There has been no drowsiness, and he is in complete possession of his mental faculties. His kind neighbour, Dr. Walters of Reigate, is in daily attendance, and he has been visited by his old pupil and friend Dr. George Johnson, to whom he calmly remarked, "This is the beginning of the end." His medical attendants are agreed that there is probably some arterial obstruction by thrombosis in the neighbourhood of the right corpus striatum.

IRISH LUNATIC ASYLUM REPORTS.

THE twenty-first report on Irish Lunatic Asylums, for the year 1881, states that at the end of the year there were in the twenty-two district asylums 8067 patients, 4685 males and 3982 females, being an increase of 311 during the year. Of 2044 admissions, 458 were relapses, and from this the deduction is made: "That while medical science is able to contend with physical affections to a great extent, the mind is beyond its control, as a rule, save when bodily diseases may have superinduced in it an unhealthy action." This would convey the impression that the mind was regarded as an entity at times entirely independent of physical causes. Would it not be possible to suggest several other equally probable explanations of these figures. The recoveries are estimated at 40 per cent. on admissions, or 11½ per cent. on the daily average of patients. The death-rate is low, 7¼ per cent. on the number under treatment. The inspectors defend themselves from a charge of a disposition to extravagance very tersely and truly. They say: "A waste of money arises when an expenditure is too restricted to be useful. In fact, our only desire is to locate in public asylums suitable inmates, ensuring at the same time in each district a becoming receptacle for others who need less attention." Great liberality

in salaries and pensions of the asylum staffs is advocated, and would seem to be very necessary from an examination of the tables in which the former are stated. There are 3600 persons mentally afflicted in poor-houses, and the inspectors advocate that a poor-house in each asylum district should be solely devoted to the care of harmless lunatics, thereby avoiding the construction of additional asylum accommodation, many of the asylums already containing a considerable excess of patients over their estimated capacity. There can be little doubt that this plan is well adapted to the wants of the country, and is an example of the practical appreciation of their work which the inspectors manifest throughout their report.

THE NEW BUILDINGS OF THE MEDICAL SOCIETY OF LONDON.

SOME months ago the property between the Medical Society's Rooms in Chandos-street and the corner house in Cavendish-square was to let. The Society has been fortunate enough to secure it together with its old holding on a long lease at very reasonable terms. This has afforded an opportunity of constructing additional accommodation, as well as of remodelling the existing premises of the Society. The part of the building to be erected on the newly-acquired land has already advanced considerably, and is nearly ready to be roofed in. The new building, as designed by Mr. H. C. Boyes, of 9, Bow Churchyard, will extend along a frontage of about 120 feet in Chandos-street. It will comprise two stories, covered by a Mansard roof containing a third. The plan of the ground-floor, besides an entrance and staircase-hall, with ample cloak-room and lavatory accommodation, provides several suites of offices, which will be sub-let, as now, for business purposes. From the hall a semicircular staircase ascends to a wide landing, from which the rooms of the Society open. To the left is the council-room, and a corridor leading to a small library to be occupied by the Entomological Society. Facing the stairs a door gives access to the present meeting-room, which, enlarged by an annexe, is retained as the future library. To the right opens the large new meeting-room, 38 ft. by 26 ft., and 19 ft. high, occupying all the north wing of the old building. From the corridor a staircase leads to the Registrar's apartments above. It has fortunately been found possible to regulate the builder's operations so as not to interfere with the working of the Society during its session. The meetings will take place as usual in the existing meeting-room until the new one is ready to receive the Fellows. Though access to the library is at present debarred, this inconvenience will, it is hoped, be shortly removed. On the completion of these alterations it is believed that this ancient Society will be housed in a more commodious manner than any of its younger rivals; while its very valuable, and far too little known library, so rich in old medical works, will be more advantageously placed than hitherto.

THE ORGANISMS OF TYPHOID.

MARAGLIANO of Genoa has published, in the *Centralblatt für die Med. Wissenschaften*, an important note on the uniform occurrence of organisms in the blood of patients suffering from typhoid. He has found them in the blood of the spleen as well as in that of the general circulation. The blood was obtained by means of a hypodermic syringe, the middle of which was passed through the abdominal wall into the substance of the spleen. Dr. Sciamano of Rome first showed that blood may be thus obtained from the substance of the spleen during life without any injurious consequences. The blood of the general circulation was taken from the tip of the finger. In each method every precaution was taken to avoid the accidental introduction of organisms. The examination, in this way, of fifteen patients gave the following result. At the height of the disease the blood of the general circulation contains micro-organisms both isolated and grouped. These consist, almost exclusively, of spherical bodies, which have a delicate contour, appear to be homogeneous, and are analogous to micrococci. Some of them are mobile. Similar organisms, again, were seen in the blood of the spleen, and in it, too, were others, rod-shaped, also with delicate outlines, perfectly corresponding to those described by Eberth and Klebs. During convalescence these micro-organisms lessen in number in both the splenic and systemic blood. When quinine was given to the patient in large doses the organisms either disappeared from the blood, or were present in it only in small number. The blood from both the finger and the spleen was treated by the method of fractional culture, and a large number of rods were then obtained, similar to those seen in the fresh blood except that some of them were of greater length. The presence of such organisms in the blood of the spleen after death had been previously established by Sokoloff and Fischel, but Maragliano is the first who has demonstrated their presence in the splenic blood during life. He avoids the expression of any opinion as to their relation to the disease.

REMOVAL FROM THE MEDICAL REGISTER.

THE customary caution as to the risk of being erased from the Medical Register is published by the Registrar in our advertising columns. It cannot be too clearly apprehended by our readers that any change of address should be intimated to the Registrar of the division of the kingdom in which their registration first took place; and that in the event of letters of inquiry being sent to registered practitioners and remaining unanswered, the Registrar's instructions are to erase their names. Much irritation has been caused by such erasures, but they are strictly in accordance with the Act of 1858. They may all be avoided in the Register of 1883, which is now being prepared, by the timely answering of letters addressed by the Registrar to registered persons, and by timely intimations of change of residence. It is exceedingly unsatisfactory to find one's name omitted, without one's crime, from the great roll of the profession. We are convinced that it is the desire of the Registrar to make his Register as correct as possible, and that the profession will co-operate with him in making it so, even if they think that the method prescribed in the Act admits of amendment, like so many other parts of the Act of 1858.

ILLEGITIMACY AND MANSLAUGHTER.

DR. A. L. WEATHERLY, deputy coroner for Somerset, is reported by the *Bristol Post* to have made some very appropriate observations in the case of an inquest on the body of a newly-born female child, the illegitimate offspring of a young woman in the service of a family at Poolridge. As the servant was found guilty by the jury of manslaughter, we think it well to postpone comment, excepting on one point. Both the mistress of the girl and an elderly woman who frequently worked at the farm suspected that the girl was in the family way. It is wrong when experienced women notice young women to be in the family way, and even suspect them to be in labour, not to say anything about it. It is no doubt painful to recognise that a young woman is illegitimately pregnant; but it is monstrous to refuse to recognise it. As the coroner pointed out in this case, the consequence of doing so is that a young woman finds herself committed on a charge of manslaughter. Had her friends or her mistress, or her fellow servant, determined to ascertain the truth of their suspicions, the girl would have been saved from an extremely painful position.

VISITATION OF THE MEDICAL CORPORATIONS BY THE MEDICAL COUNCIL.

OUR readers are aware that the examinations of the nine medical and surgical corporations of the United Kingdom were recently visited and reported on by three visitors of acknowledged competence and impartiality, Professor Gairdner, Mr. Stokes, and Mr. Teale. Though the immediate result of their reports and the conclusions of the Council were somewhat disproportionate to the expectations raised and the money expended on the visitation, yet the reports contain a great amount of information and criticism. These reports and the answers of the bodies to the criticism of the visitors make up a volume of considerable interest and value at the present moment. It is made much more so by an index, the preparation of which must have entailed great labour and trouble. This, together with all the publications of the Council, can be had of Messrs. Spottiswoode.

BANQUET TO THE MEDICAL OFFICERS OF THE EGYPTIAN EXPEDITION.

WE understand that it is intended at an early date to give a banquet of welcome to the medical officers of the army and navy who served in the Egyptian expedition. The chair will be taken by Sir William Jenner, Bart., K.C.B., President of the Royal College of Physicians. Sir James Paget, Bart., Sir Joseph Fayrer, K.C.S.I., Medical Officer to the India Board, and Mr. T. Spencer Wells, President of the Royal College of Surgeons, have expressed their intention of attending the banquet, and Dr. Crawford, Director-General of the Army Medical Department, and Dr. Reid, Director-General of the Naval Medical Department, will also be present as guests. A committee is being formed to make the necessary arrangements; meantime, communications from gentlemen desiring to attend may be addressed to Mr. G. Eastes, M.B., 69, Connaught-street, Hyde-park, W.

BLOOD AND OZONE.

IT is usually asserted by physiologists that even traces of ozone, introduced into the blood, injure it by leading to the formation of methæmoglobin, and conversely ozone in contact with blood quickly undergoes destruction. The question has been reinvestigated by Professor Binz of Bonn, who has found that pure ozonised air has an action on human beings quite similar to that of nitrous oxide. Persons whose respiratory passages are so little irritable that they can take a full inhalation, experience a brief agreeable stimulation, and then become somnolent and actually fall asleep for a short time. This observation has led him to make further experiments on the tolerance of blood for ozone. He found that a stream of ozonised air might be passed through defibrinated blood for at least an hour without the occurrence of any change in its aspect, or microscopical or spectroscopical appearances. The only difference is that the alkalescence diminishes more than in similar blood, through which simple pure air is passed. The ozone manifestly first combines with the dissolved organic elements of the blood, and only acts on the formed elements after prolonged action. A small quantity of blood subjected to a similar current of ozone first becomes bright red, then darker, and, at the end of an hour, it resembles reduced blood in aspect, but differs from this in not regaining its tint when shaken up with air. Its spectrum presents weak but unmistakable oxidation lines, which are not accompanied by methæmoglobin lines until the following day. Microscopically the blood-corpuscles were pale, and apparently spherical, and no fragments were visible. In another series of experiments the ozonised air was passed through fresh blood, to which a little saline solution had been added. At the end of ninety minutes the blood was uncoagulated, dark, but still showing oxygen lines, and the corpuscles had lost their depressions. A longer exposure rendered the blood very dark, and the next day the corpuscles had disappeared, and the methæmoglobin had considerably increased in quantity. A solution of pure oxyhæmoglobin resisted the action of the ozone much less than the blood, although it never presented alterations in less than ten minutes. Binz further ascertained that the decomposition of ozone by blood is not complete; considerable traces seem to remain in the blood in an unaltered state, and can be recognised by the usual tests.

OUR ORIGIN AS A SPECIES.

THE first number of *Longman's Magazine*, to whose prosperity we wish well, contains an article by Professor Owen with the above title, and which is a polemic upon a paper by Grant Allen in a late number of the *Fortnightly*. That author had rather strongly insisted on the evolution of man from some man-like animal developed from the anthropoid apes, and living about the mid-miocene period; a creature that was partly frugivorous, partly carnivorous—a tall and hairy creature, more or less erect, but with slouching gait, black-faced and whiskered, with prominent progunthous muzzle and large pointed canine teeth, those of each jaw fitting into an interspace in the opposite row; the forehead low and retreating, with bony bosses underlying the shaggy eyebrows; his brain about halfway between that of the anthropoid apes and that of the Neanderthal skull. Then came the Pleistocene period, and with it the age of the cavemen, who presented some similarity to the existing Eskimo, but with lower foreheads, with high bosses like the Neanderthal skull, and big canine teeth, like the Naulette jaw. Professor Owen, in commenting upon these statements, observes that the human jaws of this supposed period which he has examined give no evidence of a canine tooth of a size indicative of one in the upper jaw necessitating such vacancy in the lower series of teeth, as the apes present. He refers to the skulls he himself obtained from the cavern at Bruniquel, and now in the Museum of Natural History, which show neither lower foreheads nor higher bosses than do the existing races of mankind, and he makes an observation which, coming from such an expert, is of great weight—that, so far as his experience has reached, there is no skull displaying the characters of a quadrumanous species, as that series descends from the gorilla and chimpanzee to the baboon, which exhibits differences, osteal or dental, on which specific and generic distinctions are founded, so great, so marked as are to be seen in the comparison of the highest ape with the lowest man. Clearly the missing link has not as yet been discovered, and many more undoubted specimens of river-drift and cave-men must be collated before any positive statements can be made.

PEAT DRESSINGS.

AT the suggestion of Dr. Neuberg, Professor Esmarch has recently been using in his hospital at Kiel bags of peat-dust impregnated with an antiseptic. This dust is very light and powerfully absorbent of gases and liquids, taking up more fluid, it is asserted, than jute, gauze, or cotton wool—even to nine times its own weight; it is also soft and elastic, and in Germany very easily obtained and inexpensive. The peat may be used alone in bags of muslin, but the more approved method is to have two bags of muslin—one twice the size of the other—purified by being wrung out in carbolic solution, 5 per cent. The smaller is filled with the peat-dust containing 2½ per cent. of iodoform, and is placed immmediately in contact with the wound. The larger bag is filled with the peat-dust soaked in carbolic solution, 5 per cent., and this is placed over the other. Such

a dressing may remain undisturbed for from several days up to a fortnight, and it is stated that excellent results have been obtained with it. This we do not doubt, but we are unable to believe that this newest form of "antiseptic" dressing will in any way revolutionise surgical practice or become generally adopted.

NOTIFICATION OF DISEASE TO THE VICAR!

THE heading of our annotation may suggest an additional argument in favour of notification to the sanitary authority. The opponents of such a measure, in whatever form, may see that the notification of infectious disease is so taking hold of the public mind that, if the medical officers of health and the sanitary authorities do not make themselves recipients of the information, other authorities will intermeddle. In *St. James's Parish Magazine*, Tunbridge Wells, the following suggestion is made: "Notice of any infectious case, such as scarlatina, measles, &c., should be at once communicated to the vicar, that it may be promptly taken in hand, and the infection be as far as possible prevented from spreading." We should have thought that the vicar had quite enough on hand, in all the sin and vice of his parish, without the addition of cases of measles and scarlatina. But it is clear that the sanitary authority of Tunbridge Wells has a serious rival in the ecclesiastical sphere.

EXCISION OF THE PYLORUS.

ON the 17th inst., at St. Thomas's Hospital, Mr. Sydney Jones removed the pylorus for malignant disease. The patient, aged fifty-seven, was under the care of Dr. Bristowe. A large growth completely surrounding the pylorus, together with some affected glands, was removed. The operation was a prolonged one, and was carried out with antiseptic precautions. The patient was much emaciated before the operation, and unfortunately did not rally from the shock, dying about six hours afterwards. We hope shortly to publish the particulars of the operation and morbid appearances.

WE regret to have to record the death of Wm. Alexander Anderson, M.D. Aber., F.R.C.S. Eng., of Uxbridge. The deceased had been in the Commission of the Peace for Middlesex for some sixteen years, and was one of the most active members of the Uxbridge bench of magistrates up to the time of his death, which took place suddenly on Sunday last. Dr. Anderson was formerly assistant-surgeon at the Royal Naval Hospital, Plymouth, and took his Fellowship of the English College of Surgeons in 1853.

THE Regius Professor of Medicine at the University of Oxford has issued a notice requesting candidates for a certificate of proficiency in subjects bearing on Preventive Medicine and Public Health to send their names to him on or before Friday, Nov. 10th. No person can be admitted as a candidate who has not obtained the degree of Bachelor of Medicine in the University.

THE terrible hurricane which has played such havoc with the buildings of Manilla would seem to have verified the truth of the adage that "it is an ill wind that blows no one any good." It is stated that on the first day after the storm not a single case of cholera occurred in the town or the island.

IN January next (says the New York *Medical Record*) a night medical service will be established in Brooklyn. In Washington, D.C., where the plan has been in operation some little time, the calls average between one and two every night.

BY the death of James W. Johnston, M.D., Honorary Surgeon to the Queen and Inspector-General of Hospitals and Fleets (retired), a good-service pension of £100 a year is placed at the disposal of the First Lord of the Admiralty.

DR. F. W. KÖHLER, of Louisville, performed resection of the stomach for cancer on September 2nd last. This operation is stated to be the first of its kind done in America.

TREATMENT OF THE SICK AND WOUNDED IN EGYPT.

[FOR the following account we are indebted to Mr. Edgar Crookshank, house-surgeon of King's College Hospital, who, having arrived at Ismailia in the *Lydian Monarch*, was attached to the medical staff in Egypt, and followed the campaign from the base of operations to Cairo. His notes are not only valuable from his previous acquaintance with the methods of antiseptic surgery as carried out in its minutest detail at King's College Hospital, but more particularly as they tend to show that the alleged deficiencies in the care of the wounded and the administration of medical comforts were based on a want of sufficient professional acquaintance with the working of the Medical Department.—ED. L.]

Various accounts having been circulated with regard to unsatisfactory treatment of the sick and wounded in Egypt, a few notes of my experience during the campaign may be of interest to the profession.

Arriving at Ismailia in the *Lydian Monarch*, I was attached to the base hospital on Aug. 29th. Having the free run of the hospital, and being desirous of gaining experience in every particular, I keenly observed its working. At the time I arrived, I was greatly pleased with the cleanliness, ventilation, and general sanitation of the building. In the surgical division in which I worked, I was at once struck with the wholesome condition of the wards and the absence of that peculiar unhealthy atmospheric condition which so speedily results in overcrowded or ill-ventilated hospitals. The isolation in tents of the infectious cases, the suspension of carbolic sheeting, and the use of tea-leaves sprinkled with carbolic acid in sweeping out the wards, were the chief means in use for the preservation of the purity of the air. Equally satisfactory was the general appearance of the wards, the patients lying on mattresses arranged with sufficient interval to secure for each the requisite amount of ward space, and surrounded, when the cases were severe, with mosquito curtains. Folded coats and helmets were neatly arranged in the corners or where they were out of the way; and in the centre, chatties, and occasionally even flowers, were placed on empty packing-cases covered with clean towels.

Whilst dressing patients and conversing with them, with the exception of the incidents to which I will subsequently refer, I always found that they expressed themselves as comfortable, as having all they wanted, and grateful for the care and interest taken in them by the surgeons. The room set apart for operations, containing an operating table in the centre, and an extemporised table on one side, arranged with all the instruments, dressings, bowls, sponges, and solutions necessary, could not possibly have been more suited for its purpose if it had been the operating theatre of a civil hospital. Whenever a serious case was under notice a consultation of two or more surgeons was held, and the case thoroughly entered into and discussed. Conservative surgery was the golden rule persistently adhered to, and

therefore it will be seen how groundless could be any complaint of inattention or unnecessary mutilation. One case has been especially referred to—viz., that of a Life Guardsman, whose arm was amputated at the shoulder-joint. This required the services of two surgeons to attend to the dressing daily, and as, arriving shortly after the operation, I was requested to be one of the two, I inquired minutely into all the details of the injury and of the operation, and I am perfectly sure that chloroform was administered. With regard to his after-treatment, I can speak with certainty; he was not only always dressed with the utmost care and gentleness, but any little fancy that he had was promptly attended to. For instance, he used to ask for champagne, beer, chicken, fish, beefsteak or chops, and a special requisition was then made, and if it were possible—which was nearly always the case—his wish was gratified. The report of the deficiency of anæsthetics was utterly inaccurate. I was myself detailed for the inspection and distribution of antiseptic dressings and appliances which had been supplied in large quantities, and it was necessary for me to go through the invoices of all the medical stores deposited in the cellars of the hospital. I remarked, while doing so, how amazed I was at the quantity of every drug, dressing, and appliance that could possibly be required, and my attention was specially drawn to the rows and rows of bottles of ether (in addition to the chloroform)—a most gratifying sight for those who of late have commented so much on the superiority of this anæsthetic. At the majority of the operations at the base hospital I was present, and not only in operations, but also in all difficult cases where it was necessary to inflict pain in making a careful examination, an anæsthetic was administered. The heart having been examined, chloroform was nearly always used, being given by means of Skinner's inhaler or by the Listerian method, on a towel. Such was my experience at the base.

On September 11th I was ordered to proceed to Kassassin, and, being attached to the advanced-field hospital, I accompanied the force and was present at the battle of Tel-el-Kebir. From the battlefield the wounded were brought by the stretcher- and dhoolie-bearers to tents which were pitched by the side of the canal. Cases and panniers were quickly opened, and everything was ready when the wounded came pouring in. The surgeons and men of the Army Hospital Corps worked with such energy and rapidity that the amount of work done in the time can only be accounted for by sympathy for the sufferers, and the earnest desire to attend to each one immediately on arrival, enabling them to work uninterruptedly for hours, and to battle against the prostrating effect of the sun. Cases in which bullets were immediately under the skin and could be removed by a small incision were attended to at once, an anæsthetic not being required, and it was marvellous to observe how the despondent and anxious look of the sufferer who begged for the bullet to be taken out was instantly changed for an expression of delight when the unwelcome visitor was put into his hand to be taken home and proudly shown as a trophy among his friends. Opium was administered to those in pain, filtered water in abundance to the thirsty, and nourishment in the form of beef-tea and milk was ready prepared in pails. As soon as dressed the wounded were carefully and gently carried a few yards and placed in cutters and flat-bottomed boats, strewn with hay, which when filled were towed along the canal to Kassassin, returning when empty for another batch. I accompanied one convoy which started in the evening and arrived late the same night. I was delighted with the easy and pleasant motion, and the absence of the jolting of vans or trains, so great a boon in the case of gunshot fractures. On arrival at Kassassin their destination was the canal-lock hospital. Those requiring it were dressed again next day, and while assisting in doing this I took note of the administration of champagne, and of the plentiful supply of ice. From Kassassin in the afternoon I accompanied a train full of wounded, assisting the surgeon who had been sent in charge. Good water, lime-juice, brandy, and Liebig's extract were supplied for the wounded during the journey, and whenever a stoppage occurred every carriage was looked into and medical comforts supplied to those in need of them. On our arrival at Ismailia station the same evening a surgeon met the train with pails of tea, from which basins and mugs were filled and handed round. So that with regard to the treatment of the wounded during their transport by rail or canal on every occasion on which I had the opportunity of witnessing it, nothing more could have been done. A short distance by the new rail then brought us to the doors of the base hospital. The antiseptic treatment which had been carried out on the battlefield was continued at the base hospital, and carefully followed out until all the wounded were transferred to ships for England; the results obtained so far reflected the greatest credit on the surgeons who employed this method. When ready to be transferred, the sick and wounded had only to be carried a few paces to the nearest point of the canal, in consequence of the dam, constructed at Tel-el-Kebir by the Egyptians, having been cut through after the fight, so that the level of the canal at Ismailia rapidly rose; the canal lock was utilised, and flat-bottomed boats, drawn by a steam pinnace, conveyed the wounded to the vessels in the lake. Practically, therefore, there was water transit from the battlefield to England. The incidents to which I referred were such as follows:—The wounded at the base were dressed antiseptically, and the surgeons in making their daily rounds examined the dressing, and passed over those cases in which, as is characteristic of this method, it was not necessary or even advisable to change it for two or three days. This was in several cases the cause of grumbling and discontent. The soldiers' idea was that if they were not dressed every day they were not being treated properly, so that it became necessary to explain to them that the fact of their not requiring to be touched was a proof that everything was going on well. It is easy to see how a misunderstanding and misrepresentation of this might lead to the report that the wounded were so neglected that even at the base hospital they were left for several days without being dressed! Again, one night a batch of wounded arrived. Nourishment, as usual, was supplied to all previous to their being told off to their respective wards. Next morning, on interrogating a patient as to how he was, he said he was starving, as he had had nothing for nearly two days. I immediately asked him how it was that he missed his turn the night before, and whether he had not had some tea, beef-tea, or milk on arrival. He replied that he did not call that anything, what he wanted was something solid. Anyone believing the man's first statement, without further question, might have been easily misled into the belief that he had actually been starved. From Ismailia, when the hospital had been cleared of all its surgical cases, I proceeded to Cairo, where I frequently visited the Citadel hospital, and found everything equally satisfactory. From thence I went to Alexandria, and re-embarked in the *Lydian Monarch*. Like other civilians, I had formed an erroneous opinion as to the value and efficiency of military hospitals. I have now learnt from my experience in this campaign that not only in essential points are they as well ordered and managed as the best civil hospitals, but that many lessons of great value might be learnt from them by the lay and medical authorities of even the best managed hospitals of our large cities.

Public Health and Poor Law.

LOCAL GOVERNMENT DEPARTMENT.

REPORTS OF INSPECTORS TO THE MEDICAL DEPARTMENT OF THE LOCAL GOVERNMENT BOARD.

Enteric fever at Clapham.—A prevalence of enteric fever in Clapham, and which was locally attributed to the use of milk from a certain dairy, was recently brought under the notice of the Local Government Board, and they instructed their inspector, Dr. Parsons, to inquire into it. Twenty-one persons in sixteen households appear to have been affected, the attacks having occurred in June and July last. Nearly all the houses affected were of a superior class, and they were either situated on the edge of Clapham Common or were widely scattered in the neighbourhood; no two being in the same, or even in adjoining streets. The water-supply was mainly from the Southwark and Vauxhall Water Company; some

three households had a supply from the Lambeth Company; and one used a well on the premises. Investigation exhibited no one sanitary condition as a cause in common to the households affected. When, however, the question of milk distribution came under inquiry suspicion at once attached to the supply of one milk-dealer who obtained a part of his milk from two dairy-farms at Musbury near Axminster. His customers, who were 118 in number, may be divided as follows: eighteen, including a public institution, took "nursery" milk alone; eight used both nursery and ordinary milk; and ninety-three the ordinary milk alone. The enteric fever was found to be entirely limited to the consumers of the ordinary milk, one in seven of every house so supplied being affected. On the supposition that the fever was conveyed by the milk this proportion seems a small one, but it is possible that, in many of the households which escaped, milk was used only in small quantities, and it is further believed that a large consumption implied the use of the article as a beverage uncooked, whereas a small consumption referred to its use in tea, puddings, &c. Several of the houses taking large supplies were affected with the disease. The ordinary milk was supplied from the two farms referred to, and these were in consequence at once inspected. Neither of them exhibited the sanitary conditions which should exist on a dairy-farm. At one the water was derived from a well sunk in a gravelly soil, and was shown on analysis by Dr. Dupré to be largely polluted by sewage or surface drainage, being entirely unfit for drinking or culinary purposes. About eight yards from the dairy and twelve yards from the supposed position of the well belonging to it is a brook which higher up flows through a rough stone sewer. Now, last winter six cases of enteric fever occurred in Musbury, the last one being still ill during the month of March; and it is known that the infectious excreta from this case were thrown into a privy with a vault of primitive construction, from which, when full, the contents are got rid of by pouring down water, and washing them away through a rough drain into the sewer. Having regard to all these circumstances, we gather that the persons affected with enteric fever were not specially exposed to any known local conditions likely to have brought about the disease, that they were not in any close personal relation with each other, but that they had a milk-supply in common, and that this supply came from the dairy-farm in question at Musbury. At the latter village we have further the existence at no remote date of enteric fever, with the possibility of access of the specific poison to the dairy-farm well by percolation from the sewage-polluted brook through a porous gravelly soil; and we feel bound to accept the view expressed by Dr. Parsons, that the water from this well being used for dairy purposes, it is highly probable, if indeed not practically certain, that the infection was distributed by the medium of milk.

Diphtheria at Folkestone.—A large fatality from diphtheria in the Folkestone urban district has been under investigation by Dr. Parsons, on behalf of the Local Government Board. The disease commenced in October, 1881, and continued without interruption until the end of May, when as many as 60 fatal cases had been registered, in addition to certain deaths from so-called croup and pharyngitis. This indicates a very serious outbreak, and, unless it was of a specially fatal character, there must probably have been over 300 attacks in all. Of 152 new cases occuring in seventy-five households, and which came under inquiry, the frequency with which the first case in each household proved fatal is noteworthy. Thus, of twenty-seven households in which both fatal and non-fatal cases occurred, in nineteen the first case proved fatal, and in only eight the first case recovered. No satisfactory history could, at the date of the inquiry, be elicited as to the origin of the epidemic. The first person attacked was a child, who did not appear to have been in contact with other persons affected, either in Kent where the disease was somewhat prevalent, or in connexion with the French traffic from Paris, in which city many cases prevailed. As to its spread, it is clear that in many cases the disease was carried from household to household by unrestricted personal communication, and this apart from the ordinary method of infection as the result of school attendance. There was no community of milk-supply, and a large number of houses attacked received their water from the public service which, though intermittent, did not come under suspicion. As regards other matters, however, it is most unfortunate to find that an inspector, in dealing with a health resort, finds himself obliged to report that as regards local wells "no pains are taken to exclude surface soakage, hence they are very liable to become contaminated." And again, as regards the houses, it appears that "in almost all .....in which diphtheria has occurred, dangerous communications with the drains were found, of a nature to allow the entry of sewer air into the house." Folkestone has begun to get rid of its shallow surface wells, and, according to Dr. Parsons, it is locally admitted that the number of sewer ventilators is insufficient. Further action should not be delayed, for a good water-service is available, and the circumstances of the sewers are exceptional, owing to the fact that the sewer outlet is tide-locked during the greater part of the twenty-four hours. Amongst the recommendations which are forwarded (together with Dr. Parsons' report) to the Folkestone Town Council is one urging improvement in the ventilation of the public sewers, and the severance of the direct connexion existing between drains and houses. Folkestone possesses an excellent hospital for infectious diseases, but for some reason or another it was allowed, as regards this serious epidemic of diphtheria, to lie all but idle, for "only a single case of that disease" was admitted. The lesson taught in that one instance is, however, noteworthy, for it is reported that in the household from which the patient came no further cases occurred.

VITAL STATISTICS.

HEALTH OF ENGLISH TOWNS.

In twenty-eight of the largest English towns, 5468 births and 3398 deaths were registered during the week ending the 21st inst. The annual death-rate in these towns, which had been equal to 19·9 and 21·7 per 1000 in the two preceding weeks, declined again last week to 20·4. The lowest death-rates in these towns last week were 13·7 in Bolton, 14·1 in Norwich, 15·1 in Nottingham, and 16·6 in Bristol. The rates in the other towns ranged upwards to 25·9 in Birkenhead, 28·3 in Cardiff, 31·0 in Preston, and 34·2 in Sunderland. The deaths referred to the principal zymotic diseases in the twenty-eight towns were 535, and within 7 of the number in the previous week; 136 resulted from scarlet fever, 118 from diarrhœa, 92 from "fever" (principally enteric), 91 from measles, 57 from whooping-cough, 35 from diphtheria, and only 6 from small-pox. No death from any of these diseases was recorded in Bolton, whereas they caused the highest death-rates in Preston and Sunderland. Scarlet fever showed the largest proportional fatality in Sunderland and Sheffield; measles in Wolverhampton and Sunderland; and "fever" in Leeds, Blackburn, Liverpool, Portsmouth, and Preston. The mortality from whooping-cough was generally below the average. The 35 deaths from diphtheria in the twenty-eight towns included no fewer than 28 in London, whereas but 7 were recorded in the twenty-seven provincial towns, of which 2 occurred in Birmingham. Small-pox caused 3 deaths in London, 2 in Newcastle-upon-Tyne, and one in Manchester. The number of small-pox patients in the metropolitan asylum hospitals, which had been 79 and 84 on the two preceding Saturdays, declined to 78 at the end of last week; only 8 new cases of small-pox were admitted to these hospitals during the week, against 14 and 13 in the two previous weeks. The Highgate small-pox hospital contained 8 patients on Saturday last, no new case having been admitted during the week. The deaths referred to diseases of the respiratory organs in London, which had been 253 and 302 in the two preceding weeks, were 290 last week, and 36 below the corrected weekly average. The causes of 76, or 2·3 per cent., of the deaths in the twenty-eight towns were not certified either by a registered medical practitioner or by a coroner. All the causes of death were duly certified in Bristol, Leicester, Brighton, and in four other smaller towns. The proportions of uncertified deaths were largest in Salford, Hull, Preston, Huddersfield, and Cardiff.

HEALTH OF SCOTCH TOWNS.

The annual death-rate in the eight Scotch towns, which in the two preceding weeks had been equal to 22·3 and 19·2 per 1000, was 19·7 in the week ending 21st inst.; this rate was 0·7 below the mean rate during last week in the twenty-eight large English towns. The deaths referred to the principal zymotic diseases in these Scotch towns, which had been 117, 107, and 99, in the three pre-

vious weeks, further declined to 96 last week; they included 28 from diarrhœa, 23 from scarlet fever, 18 from whooping-cough, 16 from diphtheria, 8 from "fever," 3 from measles, and not one from small-pox. The deaths from these principal zymotic diseases averaged 4·1 per 1000 in the eight towns, and exceeded by 0·7 the rate from the same diseases in the large English towns. The 28 deaths attributed to diarrhœa exceeded the number in the previous week by 2, and were 3 above the number in the corresponding week of last year. The 23 fatal cases of scarlet fever, exceeded the number returned in any recent week, and included 8 in Glasgow, 8 in Edinburgh, and 8 in Paisley. The 18 deaths from whooping-cough were within 1 of the number in the previous week; 13 were recorded in Glasgow, 3 in Greenock, and 2 in Dundee. The 16 deaths referred to diphtheria included 8 in Glasgow and 4 in Edinburgh. Eight of the 5 deaths from "fever" were returned in Glasgow. The deaths referred to acute diseases of the lungs in the eight towns, which had been 102 and 100 in the two preceding weeks, rose to 108 last week, and exceeded by 5 the number in the corresponding week of last year.

HEALTH OF DUBLIN.

The rate of mortality in Dublin, which had been equal to 19·9 and 24·4 per 1000 in the two preceding weeks, declined again to 22·5 in the week ending the 21st inst. During the first three weeks of the current quarter the death-rate in the city averaged 22·3, against 19·8 in London and 17·3 in Edinburgh. The 150 deaths in Dublin last week showed a decline of 13 from the number in the previous week, and included 4 which were referred to diarrhœa, 2 to scarlet fever, and 2 to whooping-cough. Thus the deaths from these principal zymotic diseases, which had declined steadily from 28 to 12 in the five preceding weeks, further fell last week to 8; they were equal to an annual rate of but 1·2 per 1000, the rate from the same diseases last week being equal to 3·4 in London and 3·6 in Edinburgh. The 4 fatal cases of diarrhœa showed a further decline from the numbers returned in the seven preceding weeks. The 2 deaths from whooping-cough corresponded with the number in the previous week, while those of scarlet fever exceeded recent weekly numbers. Only once previously, since the beginning of the year, has a weekly return for Dublin shown no fatal case of "fever." The deaths of infants showed a decline, whereas those of elderly persons exceeded the numbers returned in recent weeks.

THE POPULATION OF QUEENSLAND.

An official synopsis of the census enumerations of the population of Queensland during the twenty-one years, 1861–81, has recently been issued, and contains some interesting statistics of the rapid growth of that colony. Six census enumerations were held during the above-mentioned period, and the population increased from 30,059 in 1861 to 213,525 in 1881. Thus the population at the last census was seven times that enumerated twenty years before. As might be expected, the *rate* of increase is declining, for whereas the population doubled itself in the three years between the enumerations in 1861 and 1864, the increase did not exceed 23 per cent. in the five years between the two last enumerations in 1876 and 1881. A marked feature of the population of all new colonies is the excess of males over females, and the Queensland figures show similar results; it is, however, satisfactory to find that the inequality between the numbers of the sexes is decreasing. At the five enumerations in 1861–76 the number of females to 100 males ranged between 64 and 67. During the five years 1876–81, however, the increase of 40,242 in the population was almost equally divided between the two sexes, consisting as it did of 20,316 males, and 19,926 females. In 1881, therefore, the proportion of females to 100 males had increased to 70. The age distribution of the Queensland population is fully as abnormal as that of the sex proportion. It is not surprising to find that the population contains a largely excessive proportion of young adults and of children, whereas the proportion of elderly persons is exceptionally small. The mean age of the population must also be exceptionally low, and those who still believe in the value of the mean age at death as a test of sanitary condition, would certainly find the mean age at death in Queensland very low, and would be inclined to infer that this fact afforded unfavourable evidence of the health of the population. We need scarcely point out how fallacious such an inference would be. It appears from the synopsis before us that at the last three enumerations a sickness return has been made. The heading of the columns containing the result of this inquiry is "Sickness and Accidents." The figures tell us that 647 persons were at the time of the last census suffering from sickness in private houses, and 300 in hospitals. It is difficult, without precise knowledge of the instructions given to the enumerators as to the definition of sickness and accident, to estimate the value of these sickness returns. Roughly, however, they appear to show that less than five per 1000 of the Queensland population were at the last census suffering from illness or accident. If these figures are not deceptive, they speak well for the sanitary condition of Queensland.

THE SERVICES.

ARMY MEDICAL DEPARTMENT.—Deputy Surgeon-General John Edward Moffatt has been granted retired pay, with the honorary rank of Surgeon-General. Brigade-Surgeon J. Ferguson, to be Deputy Surgeon-General, vice J. E. Moffatt, granted retired pay. Surgeon-Majors Decimus Filius de Hodgson, M.D.; David Mackie, M.D.; Charles Mackinnon; and Campbell Millis Douglas, M.D., V.C., have been granted retired pay, with the honorary rank of Brigade-Surgeon.

Surgeon-Major John Henry Beath, M.D., to be Brigade-Surgeon, vice J. Ferguson, promoted.

Surgeon-Major Henry Hummerston Burford, from half-pay, to be Surgeon-Major, vice A. G. Bartley, retired on temporary half-pay.

Brigade-Surgeon Bruce, officiating Deputy Surgeon-General, Presidency Division, Bombay, is confirmed in that grade and appointment, vice Moore, whose tenure of office has expired.

Surgeon-Major Cameron MacDowall, 3rd Bombay Light Cavalry, is promoted Brigade-Surgeon, vice Bruce, promoted.

BENGAL MEDICAL ESTABLISHMENT.—Brigade-Surgeon Alfred James Dale, to be Deputy Surgeon-General.

MADRAS MEDICAL ESTABLISHMENT.—Surgeon-Majors Henry Crocker, M.D.; Hunter Adam; and Donald Coleman McAllum, to be Brigade Surgeons.

RIFLE VOLUNTEERS.—3rd Monmouthshire: Thomas Gilbert Prosser, Gent., to be Acting Surgeon.

ADMIRALTY.—Deputy Inspector-General John Traill Urquhart Bremner, M.D., has been promoted to the rank of Inspector-General of Hospitals and Fleets, with seniority of October 21st, 1882. Fleet-Surgeons George Robertson, M.D., and George Bewsher Beale, M.D., have been placed on the Retired List of their rank.

The following appointments have been made:—Fleet Surgeon Walter F. C. Bartlett, to Pembroke-yard, vice Wilson; Fleet Surgeon James N. J. O'Malley, to the *Agincourt*, vice Bartlett.

Correspondence.

"Audi alteram partem."

"THE TREATMENT OF PAUPER LUNATICS."

To the Editor of THE LANCET.

SIR,—The letter of Sir Henry Gordon, in your last week's issue, touches a point of the greatest importance to the insane poor and to the ratepayers of the county of Middlesex.

My experience, as one of the medical superintendents of Hanwell Asylum for ten years, warrants me in the expression of the opinion I have formed, that the great want for the satisfactory treatment of the insane poor in this county is a hospital constructed and organised on the most liberal principles. Such a hospital, acting as a central receiving house, would greatly tend to check the enormous accumulation of the insane, as well by increase of cures as by preventing the sending of unfit cases to the various distant asylums, and would thus be a source of great economy. Additional economy would also result by saving the large outlay necessitated by transferring patients from one institution to another in the present hap-hazard system of distributing them. Numerous other reasons might be advanced

why a more liberal provision for medical treatment should be made, but I will content myself with one illustration.

In Scotland there are, roughly speaking, 6000 insane paupers in asylums; in Middlesex there are 5700 in the three asylums of Colney Hatch, Hanwell, and Banstead; the latter have fourteen medical attendants; the former, treated in six parochial and eighteen district asylums, have, on the most moderate computation, twenty-four. The comparison might be carried into every detail of asylum accommodation, and in regard to the relative amounts of land provided for asylum use, the inequality would be found still more striking; the one point of medical attendants is sufficient to enforce my argument. What is true of Middlesex is true to a greater or less extent of the whole of England, that, while the buildings for the detention of the insane have been provided on a liberal scale, the means for treatment, as gauged by the numbers of medical officers, have been niggardly supplied; so that in this respect England compares most unfavourably with France, Germany, America, Russia, in fact with almost every civilised country. This result has been brought about by the building funds being derived from a practically uncontrolled source; the current expenditure, on the other hand, being sharply checked by the parish authorities.

I fervently hope that, in supplying the additional accommodation now required, Middlesex will, by providing a liberally organised hospital, set an example that will tend more than anything else to check the increase in this country of lunatics needing asylum detention.

I am, Sir, your obedient servant,

Hanwell, October, 1882. H. RAYNER.

STRYCHNIA POISONING DELAYED EIGHT HOURS BY OPIUM.

To the Editor of THE LANCET.

SIR,—I think the following case may prove of interest to some of your readers from the long interval between the taking of the strychnia and the onset of the symptoms.

On June 24th last, at 1.50 P.M., I was called to a case of poisoning at the police station, and found in the guard-room a stout, healthy-looking, well-developed young woman of twenty-three, six months advanced in pregnancy, suffering from well-marked symptoms of opium poisoning. She was unable to stand without assistance; could with difficulty be made to answer questions; and her face was becoming pale and ghastly. A quarter of an hour previously she had been discovered in a semi-conscious state near the river, and in her pockets were found a two-ounce bottle containing a few drops of tincture of opium, a packet of Battle's vermin killer torn in two, and with five grains of the powder remaining, and a pill-box which afterwards proved to contain ordinary aperient pills; also a letter to her mother and father stating she intended to commit suicide. I could only elicit from her that she had poisoned herself, but I could obtain no further particulars. I gave a large dose of sulphate of zinc, which produced vomiting in a few minutes, the vomit being composed principally of fruit, and only smelling slightly of opium. After that she had draughts of hot water, coffee, and mustard and water, till her stomach was completely washed out. I left her much better at 2.45 P.M., with directions that she was to be kept walking up and down, and that I should be sent for immediately if any change occurred. I returned at five o'clock, and found her still improving, without the slightest symptoms of strychnia poisoning; so that I began to think it almost impossible she could have taken the vermin killer. In fact, the only difference the case presented from an ordinary one of opium poisoning was that the pupils were little, if at all, contracted; at any rate, not nearly so in proportion to the severity of the other symptoms. I returned about 7 P.M., and found that slight clonic convulsive movements of the hands, and in a less degree of the legs, had set in, and was informed they had commenced a little after 6 P.M. As she was very drowsy, and dropping off between the spasms, and as I thought it possible they might be in great part hysterical, I hesitated about giving chloral; but finding after an hour the convulsions increasing, both in extent and degree, I gave forty grains of hydrate of chloral, and had her removed to the union infirmary. An hour afterwards (9 P.M.) I saw the patient in company with Dr. Patterson. The spasms were now well marked, extending over her arms, hands, and shoulders, and in a less degree over her legs and feet. There was slight opisthotonos and considerable pain at the pit of the stomach, but no trismus, and but little twitching of the muscles of the face. The pulse and temperature were only slightly above normal. The opium symptoms had almost entirely disappeared. She was ordered two drachms of chloral, half a drachm to be taken every hour. For a couple of hours the symptoms increased in violence, but after that they gradually subsided, and by 4 A.M. (Tuesday) had almost disappeared. Next morning she only complained of general soreness and of feeling very hungry.

On instituting inquiries we discovered that early on Monday morning she had purchased at one shop a packet of vermin killer, and at another an ounce of laudanum, a box of pills, and a drachm of white precipitate. The latter, I may here remark, was never traced. She said herself she had taken the powder a little after 10 A.M., and immediately after two ounces of laudanum. A packet of Battle's contains two grains of strychnia, so that she must have taken almost a grain and a half, and as I did not see her till nearly four hours after, the emetics could hardly have removed it. Though the poisonous dose of strychnia, as in the case of most other drugs, varies greatly from half a grain, which quantity killed Dr. Wain in fourteen minutes, still, I think the above might under ordinary circumstances be considered a fatal dose, particularly when a person is unused to the drug. Taylor mentions four hours as the longest interval before the appearance of the symptoms, while here we have nearly a grain and half producing not the slightest effect for eight hours, during which time the patient had every symptom of opium poisoning with the exception of contracted pupils. Strychnia is said, in poisonous doses, to produce dilatation of the pupils, so that it would seem as if the strychnia must have neutralised the effect of the opium on the pupils; the opium, on the other hand, neutralising, at least for a time, the effect of the strychnia on the cord. I think this might have a practical bearing in strychnia poisoning when chloral or the other usual antidotes, Calabar bean, &c., were not at hand, for though opium is mentioned in books as an antidote, still I think it is seldom or never used.—I am, Sir, yours, &c.,

ROBERT D. W. MECREDY, M.B., C.M.

Grantham, Lincolnshire, Sept. 1882.

SUDDEN DEATH AFTER DIPHTHERIA.

To the Editor of THE LANCET.

SIR,—The following details and observations may help to explain the subject of "Sudden Death following Diphtheria," to which attention has lately been drawn in your journal.

Hitherto it has been considered by many that the action of the diphtheritic virus upon the nerve-centres was sufficient to account for sudden lethal terminations (when not obviously due to other causes), but recent observations may tend to modify that assumption.

During the Practical Pathology class at the Middlesex Hospital, in Nov. 1881, attention was particularly drawn to certain changes present in the heart of a case of diphtheria. The muscular tissue was somewhat pale and flaccid, and presented microscopically the following conditions:—Muscle fibres cloudy and undergoing fatty changes; neighbourhood of bloodvessels, interstitial connective tissue and spaces, were infiltrated by an abundant proliferation of nucleated and granular cells about $\frac{1}{2500}$ in. in diameter. Scattered here and there were also seen a few granular, yellow bodies, in size about three times that of nucleated cells, but possessing no distinct nuclei. This condition was not peculiar to any particular portion of the heart's wall, but occurred in several large unequally distributed areas. Both fatty and interstitial changes were seen together.

The following case is also in point:—

Sarah B——, aged fifteen, a domestic servant, was admitted into the Middlesex Hospital, under Dr. Coupland's care, on March 14th, 1882, with marked symptoms of diphtheria—pain on swallowing, dyspnœa, swollen parotid, submaxillary, and cervical glands, and abundant false membrane on tonsils and pharynx; tongue coated thickly; heart and lungs normal. Temperature 98·4°; pulse 64. She was ordered steam inhalations, and a draught containing perchloride of iron. The pharynx was painted with a saturated solution of bicarbonate

of soda. Diet, milk and beef-tea. The urine contained one-quarter albumen. The false membranes soon disappeared, the symptoms rapidly abated, and she seemed very much better. On March 21st she appeared greatly depressed, extremities were cold, and pulse became extremely weak. The urine contained one-quarter albumen. She was ordered a draught of ether and ammonia and brandy. Took her food fairly well. On 23rd, at 2 P.M., owing to the ward being emptied for the annual cleaning, she was removed to another ward, and at 10.45 P.M., same day, died suddenly. At the post-mortem examination both sides of the heart were found filled with coloured fleshy clots; walls pale and soft; valves healthy. The lungs were partly collapsed. The liver was of a nutmeg colour; the spleen soft, not enlarged; whilst the kidneys were swollen and bloodstained. Microscopically the heart presented similar characteristics to those previously described.

With the exception of some observations made by continental authorities—e.g., Leyden and others (*vide* THE LANCET, May 6th, 1882), comparatively slight attention has been paid in Great Britain to this condition of interstitial myocarditis (diphtheritic). Bouchut has stated that endocarditis is a common event in diphtheria; it, however, has not been present in any of the fatal cases which have occurred at the Middlesex Hospital of late years. In conclusion, allow me to note two important details of treatment, which I trust will not be considered irrelevant—viz., the application of solutions of alkalies to false membranes, and avoidance of chlorate of potash. Alkalies acting as solvents of greater portions of inflammatory exudations, are preferable to acids and astringents, since the latter produce coagulation, and therefore cause accumulation of the membrane. Chlorate of potash is contra-indicated by reason of its irritative influence upon the kidneys, and should therefore not be administered internally.

Yours faithfully,

V. A. WYATT WINGRAVE.

Torrington-square, W., Oct. 3rd, 1882.

"A SIMPLE OPERATION FOR VARICOCELE."

To the Editor of THE LANCET.

SIR,—The diagram of Mr. Dunnett Spanton, in your last impression, represents a "granny's knot," and not a "reef knot," which is on all hands acknowledged to be the superior one for subcutaneous ligature of veins. Both free ends of the wire or cord should be under or above the surface of the loop, conversely, to form the reef knot. In several cases on which I have operated for varicocele, I have done so by placing a doubled strong silver wire, one before and the other behind the veins, with the loop conversely, and passing the free ends inversely through each loop. A reef knot is thus formed which does not give way, and which can be tightened as frequently as deemed necessary by tension of the free ends, which are conveniently held *in situ* by being rolled round small corks. In performing this operation Professor G. H. B. Macleod used to include the veins by making the necessary puncture by means of a trocar and cannula, and passing the wires through the latter. I understand that now he ligatures the veins, and completely excises the intervening portion. In your impression of the 7th inst. Mr. Jalland states that he cuts the ligatures short, drops them into the wound, and closes it over. A piece of Chinese silk is used, previously "boiled for half an hour in a 10 per cent. solution, and afterwards left to soak for some hours in a 20 per cent. solution of carbolic acid." I presume this procedure is intended to kill the Chinese spores in the "Chinese silk." Not so many years ago, a man who confessed to the performance of such a fetish would run the risk of having his personal liberty somewhat circumscribed.

I am, Sir, your obedient servant,

Glasgow, Oct. 21st, 1882. D. CAMPBELL BLACK.

UNIVERSITY OF DURHAM COLLEGE OF MEDICINE, NEWCASTLE-ON-TYNE.—Sixty-one new students have entered at this College for the present year—viz., thirty-one for the full curriculum, and thirty for part of it. The latter, with one or two exceptions, are candidates for the medical degrees of the Durham University, and have entered in accordance with the regulations requiring them to fulfil a year of residence there.

EDINBURGH.

(From our own Correspondent.)

OPENING OF THE WINTER SESSION.—PROFESSOR CHIENE'S INTRODUCTION TO THE CHAIR OF SURGERY.—THE PHYSIOLOGICAL DEPARTMENT.—THE OLD AND THE NEW LECTURE-ROOMS.—CHANGES IN THE EXTRA-ACADEMICAL SCHOOL.—DR. MILLER'S INTRODUCTORY LECTURE.

THE winter session commenced on Tuesday the 24th. As yet it is impossible to give any accurate idea of the number of students, but so far as can be judged the large entries of recent years will, at least, be maintained. The dissecting rooms of the University, Minto House, and College of Surgeons, are well filled, and the active work of the session has already commenced.

Prof. Chiene, the newly appointed Professor of Surgery, delivered his inaugural address on Tuesday at two o'clock. The lecture was delivered, as is customary on these occasions, in the large chemical lecture-room of the old buildings. The Principal, the President of the Royal College of Surgeons, the professors of the University, a large proportion of the extra-academical lecturers, and many practitioners of medicine were present—indeed, I have never seen the room so completely filled as it was on this occasion. Professor Chiene, who is extremely popular, was well received, and the lecture[1] is acknowledged on all hands to have been a great success. Dr. Chiene thoroughly impressed his audience with his own earnestness of purpose, and with his determination to do all in his power to help each individual student in his work.

Professor Rutherford formally opened the Physiological Department of the new university on Wednesday, the 25th, and delivered an introductory address. The Principal of the University, the President of the Royal College of Surgeons, several of the professors, and a considerable number of practitioners were present, and the large lecture-room, which is calculated to seat 500 students, was completely filled. He reviewed the work done by his predecessors in the chair of physiology, and gave every credit to Hughes Bennett for the foresight and energy he had displayed in organising the first physiological laboratory in Edinburgh, and in having been the first in this country to organise the teaching of practical histology and other branches of practical physiology. He then described the objects to be fulfilled by the numerous departments of the new physiological laboratories, and eloquently pleaded for the endowment of research. He suggested the foundation of Fellowships for young graduates who have given proof of earnestness, of exceptional ability, and of a desire to prosecute original inquiry. By the establishment of such Fellowships, skilled and earnest workers could support themselves and at the same time devote their time and energy to the prosecution of original research, the objects of which are unselfish, and which confer unmistakable blessings on the whole of the human race. He hoped such endowments would fall, not only to the physiological laboratories of Edinburgh, but to all other laboratories in other universities and similar institutions. He announced that the first step towards the realisation of this wide scheme had already been taken, for a liberal gentleman, who desires to withhold his name, had, as a preliminary experiment, generously given five hundred a year to the University of Edinburgh for three years. By this means five working Fellowships of a hundred a year for three years had been established. The appointments to these Fellowships have just been made, and the university authorities are sanguine that the results will fulfil the expectations. He then showed how all the elaborate machinery provided for them in the new buildings was to enable the student to become a reasoning practitioner of medicine, and explained the order of study necessary for that object, illustrating the point by a quaint extract from the introduction to the first lectures on Clinical Medicine given in the Edinburgh Royal Infirmary by Professor John Rutherford a century and a half ago, in which it was pointed out how the reasoning physician differs from the empiric, and what are the studies needed to emancipate medicine from empiricism. The importance of physiological study to the psychologist and metaphysician

[1] The first part of this appears in our present issue.—ED. L.

was then explained, the point being illustrated by a brief account of the mechanism of the organs of sensation. He showed why the physiologist maintains that consciousness and sensation must be regarded as psychical expressions of the activities of nerve cells, although he was unable to offer any explanation of the manner in which they result from physical activities. Lastly, he showed how our knowledge of the telephone is calculated to alter existing theories regarding the sense of hearing, and, through the knowledge thus attained, of the other senses. The lecture occupied fully an hour and a quarter in delivery, and the fact that it was attentively listened to, long after the orthodox hour had expired, is the best proof that can be given of its exceptionally interesting nature and of the lecturer's power.

The increased comfort and advantage of the new over the old lecture-room was very apparent to anyone who attended the introductory lectures of Professors Chiene and Rutherford. The atmosphere in the old chemical lecture-room, which seems hermetically sealed up, with the express purpose of retaining as much foul gas as possible, was simply suffocating, and more than one student actually fainted; while the ventilation in the new physiological lecture-room was extremely satisfactory.

Dr. Alexander Miller has succeeded Dr. Heron Watson, who retires, as Lecturer on Surgery in the Royal College of Surgeons; and Dr. MacGillivray takes Professor Chiene's place at Minto House. Dr. P. Young gives a qualifying course of lectures on Midwifery and Diseases of Women at Park Place, and Dr. Berry Hart is to deliver a course of lectures on Diseases of Women in the same lecture-room.

Dr. Miller gave his introductory lecture on Tuesday to a large audience of practitioners and students. The subject which he selected, "Four and a half years' experience in the lock wards of the Royal Infirmary," was treated in a masterly manner, and was, in short, a summary of the lecturer's personal experience in the treatment of venereal affections. Dr. Miller promises, like his father (the late Professor of Surgery in the University), to be a successful teacher.

Dr. Claud Muirhead has been appointed successor to Dr. William Robertson, as Medical Referee to the Scottish Widows' Fund. This is a most valuable appointment, and is much coveted by the profession here.

Dr. Blair Cunnynghame has, I understand, been appointed Superintendent of the Statistical Department in the Registrar-General's Office, Edinburgh—another valuable appointment which was held by the late Dr. Robertson.

GLASGOW.

(From our own Correspondent.)

WITH regard to the chloroform question, and the rules which the managers of the Royal Infirmary proposed to lay down for the guidance of the surgeons in the administration of anæsthetics, the whole matter is now, as it should have been at first, referred to the medical committee. This removes part of the very natural objection of the surgical staff to receive instructions from a lay body, in reference to a matter purely surgical. The Faculty of Physicians and Surgeons also have departed from their intention of discussing the question. In the meantime, the public of Glasgow ought surely to be well informed in subjects physiological. During the course of this winter we are to have another course of health lectures, under the auspices of our local Young Men's Christian Association. Professor G. Buchanan delivered the first of these last week, on the structure of the body, to a somewhat select audience. The second was delivered on Tuesday, by Dr. W. J. Fleming, on digestion. In the remainder of the course are included lectures on the eye, the ear, the teeth, the skin, and the hygiene of infancy; the last of the course being, with what many regard as questionable taste, on "healthy motherhood," to ladies only. This is probably the complement of the very popular lecture delivered last year by another rising obstetrician, on "healthy womanhood." Some rather silly hostility has been manifested in certain quarters to these health lectures, on the ground mainly that they afford opportunity to ambitious men to pass before the public as learned specialists, to the detriment of their professional brethren. It is, however, surely not wrong that the public should have such subjects as those named above put before them in a simple and popular way; and by whom could such instruction be more appropriately given than by medical men?

Some months ago a writer in the *Sanitary Journal* was at considerable pains to show that various of our coast health-resorts, especially on the Firth of Clyde, were the reverse of healthy resorts; that in fact, so far as their meagre health statistics indicated anything, they proved that these places had a very exceptionally high death-rate. Amongst these towns Gourock was placed highest, with a death-rate of 36·4 per 1000. In reference to this locality, the authorities stated at the time that the majority of the deaths noted occurred in an institution, the Smithston Asylum, which, though technically in their registration district, did not really belong to them, but to Greenock. During the last few months the Gourock Police Commissioners have kept accurate mortality statistics of the borough proper, and have just published them. From them we learn that during July, August, and September, when the town is usually crowded with visitors, there occurred 33 deaths in the registration district; 15 of these took place in the Smithston Asylum, which is outside of the burgh boundary, while another was also in the registration district, but outside the same boundary, so that the actual number of deaths in Gourock proper was 17. Calculating on the last census returns, this gives a death-rate of 10 per 1000 of the population. It is right that these facts should be known, as Gourock is a much frequented watering-place.

Out of 115 students who went up recently for the first professional examination at Glasgow University, no fewer than 54 were "plucked." This is a very high percentage of rejections, and points either to great stringency of examination, or to a falling off in the quality of the men presenting themselves. The subjects included in this examination are elementary anatomy, chemistry, and botany.

SCOTTISH NOTES.

(From our own Correspondent.)

THE proper teaching of pathology at Aberdeen is not likely to be facilitated if action is taken on the lines suggested by the Infirmary Committee at their meeting last week. Compromise may in many cases be necessary, but this seems emphatically a case where firmness was demanded. The committee will recommend to the general court of directors, meeting in December, that their present pathologist shall take the duties alternately with the newly-appointed professor. Had this been an amicable arrangement between Dr. Rodger and Professor Hamilton, discomfort might possibly have been avoided, but notoriously this is not the case; and it is hoped that by December a clearer course may be open. Dr. Rodger deserves every consideration from the directors; he has signified no wish for assistance in the performance of his duties, and has offered to the professor the free use of what material the infirmary may afford, as well as full advantage of the museum he has done so much to render valuable. If it be true, as is asserted, that Dr. Hamilton made formal application to the directors to be appointed pathologist, well knowing that there was no vacancy in that office, and that he is not willing to accept Dr. Rodger's offer, which met the views of the Museum Committee, there seems no proper course but to refuse Dr. Hamilton's application, and that on the simple ground that there is no vacancy.

Your strictures upon the Edinburgh Colleges regarding the manner of election to the Fellowship, excite much attention in the north, and, though the profession feel a just pride in the history of those ancient bodies, there can be no doubt that the evil you refer to has been noticed for some time past, and deeply deplored. The many eminent Fellows of the College of Surgeons must feel that pecuniary consideration should not alone guide their council, and the increasing number of young and totally undistinguished names added to their list has already reduced the value of what ought to be a high honour to a position which a loyal Scotchman will not wish to characterise. As the Fellowship no longer confers such distinction in the profession as is attributed to it by the public, it becomes a hardship that its possession

should be still a *sine qua non* to men who wish infirmary appointments or recognition as lecturers at the various schools. The same remarks apply, at least, equally to the Glasgow Faculty, and, in both instances, their splendid libraries are now the chief attractions. While much has been done towards steadily raising the requirements of licentiates, it is unfortunate that the Fellowships should no longer be a guarantee of superior merit.

Prosecution for professional accounts is so unusual that the public, knowing the reluctance of medical men to appear in court, too often profit by this unwillingness, and defraud the profession of very large sums. A certain unpopularity attaches to those who in this way claim their own, and, as a consequence, isolated action is not frequently taken. It might be well if the example of Dr. Collins, late of Bervie, was followed, and able, but unwilling, debtors were made to settle their accounts. A few days ago, Dr. Collins, at the Stonehaven sheriff court, sued thirty-eight of his late patients for sums due; few, if any, of these put in an appearance, and decree was given in all the cases. Such wholesome and wholesale action will not be lost upon the district.

Dr. Andrew Wilson, of Edinburgh, has now commenced a series of lectures under the Combe Trust in various towns throughout Scotland. A general view of physiology will be presented in the eight lectures which make up the course, and special reference will be made to the value of a due observance of physiological laws if personal and public health is to be well maintained. The lecturer's past success ensures him a cordial reception everywhere, and his first two appearances in Perth indicate a hearty appreciation of physiological teaching on the part of those it is intended to reach. If all is true that is written regarding the sanitary condition and polluted water supply of that city, an excellent field is open for Dr. Wilson. In the second lecture the value of vivisection was convincingly shown.

Typhoid fever has appeared in an epidemic form in the parish of Bonhill, Vale of Leven. The cases, so far, have mostly occurred in the village of Jamestown, where about thirty people are affected. Some fatality is already reported, and the type of the disease is said to be severe.

IRELAND.

(From our own Correspondent.)

THE ceremony of conferring the degrees of the Royal University of Ireland is expected to take place on the 8th proximo. His Grace the Duke of Abercorn, Chancellor of the University, will preside.

At a special meeting of the Dublin Town Council, held last Monday, presentments amounting to £4595 were passed for the support of various hospitals. This sum included £300 to Mercer's, Jervis-street, Meath, Hospital for Incurables, Sir Patrick Dun's (with £50 for Maternity), Rotunda, Cork-street Fever, and City of Dublin Hospitals; £150 to St. Mark's Ophthalmic, Steevens', and Children's Hospitals; £520 to the Coombe Lying-in Hospital; £400 to St. Vincent's and Mater Misericordiæ Hospitals; £100 to the National Orthopædic Hospital and the National Eye and Ear Infirmary, and £25 to the Throat and Ear Hospital. A proposal to increase the salary of Dr. Whyte, coroner for the city, to £700 per annum was defeated.

The Academy of Medicine of Ireland, which is intended to absorb the Medical, Surgical, Pathological, and Obstetrical Societies, will, it is expected, begin its work in the present session. The scheme proposes that there shall be four sections, devoted respectively to medicine, surgery, obstetrics, and pathology; and the subscriptions proposed are two guineas for Fellows (of whom there will be 100), one guinea for Members, ten shillings for Associates, and five shillings for Student Associates. It is intended to issue an annual volume of Transactions, which will be supplied free to Fellows and Members.

It has recently been stated that the Belfast medical student, as a rule, does not receive any practical knowledge of the diseases of women and children, and of diseases of the eye and ear, in consequence of the Royal Hospital, the only general hospital in Belfast, not having had apartments for these diseases, or money or space to found such in an efficient manner without impairing the utility of the hospital. Further, candidates for a degree in medicine of the Royal University of Ireland are required to produce a certificate "of having attended at a recognised midwifery hospital, where clinical instruction in midwifery and diseases of women and children is given for a period of six months, or of having attended for six months at a midwifery dispensary where similar clinical instruction is given." To remedy this defect it has been proposed that the special hospitals should be amalgamated with the Belfast Royal Hospital, but there are great difficulties in the way of accomplishing the object, more particularly as regards the arrangement of the hospital fees; for it naturally follows that if these special hospitals throw open their doors to students of the Royal Hospital, their medical officers will expect some remuneration from the students attending their classes, which probably the staff of the Belfast Royal Hospital may be disinclined to agree to. The only course would be for the latter to increase their hospital fees and thus recoup themselves, or let the medical students not only take out the practice of the general hospital, but also that of an ophthalmic hospital, and attend the maternity department of the Union Hospital.

The Londonderry City and County Infirmary is an institution which alleviates a large amount of suffering at a very moderate outlay. During last year 423 accidents were treated as external cases, including dislocations, fractures, burns, and wounds, and 768 patients were admitted to the wards. Seventy-one operations were performed with only one death. The Hospital Sunday collections only amounted to £33. Collections in aid of the Dublin Hospital Sunday Fund will be held this year on the 12th November.

An address and testimonial have recently been presented to Dr. Thomas D. Foreman, Ballynahinch, previous to his departure from that place to settle in Denton, Manchester. The address was beautifully illuminated, and the presentation consisted of an elegant tea and coffee service with salver. Dr. Foreman, after the presentation had been made, entertained the deputation and a number of his neighbouring medical brethren at supper at Walker's Hotel.

PARIS.

(From our Paris Correspondent.)

AT a clinical lecture at the Hôpital de la Pitié, Professor Lasègue made some very interesting remarks on the pathology and treatment of diabetes. He divides diabetic patients into two classes: fat and lean, according as they may be found in either of these conditions. He also divides them into small and great diabetics, according to the quantity of sugar which their urine may contain. The patient that excretes twenty grammes of sugar a day may be classed among the former; those who pass more than thirty or forty belong to the second class. Professor Lasègue attaches great importance to this division, for as the small diabetic patient never becomes a great one, each class retains its peculiar character; from which it may be concluded that a patient who presents great irregularities in the quantity of sugar he excretes, and appears to pass from one class to the other, is affected more with accidental or casual diabetes than with the true affection. A third class of diabetic patients is what Professor Lasègue calls "les diabétiques fixés," and these may be found among the two former classes. In this class of cases the quantity of sugar excreted varies only by a few grammes, whatsoever the treatment employed, or the diet adopted, but this should not be considered of much importance in a prognostic point of view, the quantity of sugar not being a fair criterion of the gravity of the disease; for although the proportion of sugar in the urine may remain stationary, the extent of the general disorder of the system may still be very considerable. This, however, does not apply to patients who pass 200 or 300 grammes of sugar in the twenty-four hours: these cases must be considered exceptional, and always of some gravity. M. Lasègue establishes two other forms of diabetes, which he designates the remittent and intermittent; in the first case the quantity of sugar is considerably reduced; in the second the sugar disappears, sometimes even completely, at certain periods; and although these states of remission or intermission may be considered more favourable than the other forms, yet patients of this category become cachectic,

as patients of the other classes almost invariably do. This state, according to M. Lasègue, would constitute the principal indication of treatment; but he does not approve of the severe restrictions generally placed upon the diet and regimen of diabetic patients. He allows them to continue their usual mode of living, not even depriving them of farinaceous substances, or the use in moderation of sugar, water, or wine. As for gluten bread, so much prescribed for these cases, M. Lasègue condemns it *in toto* as not only being worthless, but it ends by disgusting the patient, takes away his appetite, and so hastens the cachectic state, which it is the very object of the physician to avert by all the means in his power.

During the holidays of the Faculty of Medicine the professors avail themselves of a well-earned respite, being replaced at the hospitals by agrégés or sub-professors. At the Hôpital de la Charité, Dr. Laudouzy, who acted for Professor Hardy, delivered a very interesting lecture on the contagiousness of tuberculosis. Dr. Laudouzy is evidently in favour of the theory of the contagiousness of this affection, as will be seen from what follows, and in order to give some support to his belief he prefaced his observations by the remark that in many diseases contagiousness is admitted without its being positively proved. Having referred to the experiments of Villemin and others in favour of this doctrine, he cited a case which came under the observation of his father, and which he thinks could leave no doubt as to the contagiousness of tuberculosis. He referred to another case recorded by Dr. Weber in support of his theory, which he considers is sufficiently conclusive. The case observed by his father was that of a young physician, who, being affected with tuberculosis, but imagining himself cured, got married and had two children. Soon after the birth of his second child he had another access of pulmonary tuberculosis, when he was advised to spend his winters in a mild climate. He consequently went to Algiers, where he spent his first winter without much difficulty. The disease, however, continued to progress, and during the second year he became considerably worse, which induced him to return to France, his native clime, where he soon died. His wife, who was till then in robust health, soon followed her husband to the grave, with one of her sons, both of whom succumbed under the same malady. This case necessarily suggests the question, whether mother and child were not affected by contagion or transmission of the malady of the father. Dr. Laudouzy replies, that although he would speak with reserve, yet it is the duty of every physician to act in such circumstances as if the contagiousness of tuberculosis had been proved. There is one point, however, in Dr. Laudouzy's lecture which deserves particular notice—viz., the mortality among military men from tuberculosis. He states that in 1872, in France, the proportion of deaths from this malady was 452 per 1000; in England it was 782 per 1000; and he makes the startling remark, that the British army, during the rigorous winter of 1854–1855, before Sebastopol, lost fewer men from pulmonary phthisis than in their barracks. In this circumstance also Dr. Laudouzy sees great presumption in favour of the contagiousness of the malady in question.

Dr. Gustave Le Bon lately submitted to the Academy of Sciences two new substances, the glyceroborate of calcium and the glyceroborate of sodium, which, according to him, possess powerful antiseptic properties, and may with advantage be substituted for carbolic acid wherever the use of the latter is indicated. They are much more soluble in water in all proportions, perfectly inodorous, and are so harmless that they may be applied even in a concentrated form to such sensitive organs as the eye. Dr. Le Bon recommends them as powerful disinfectants and for preserving meat and other alimentary substances. Before submitting these new agents to the Academy, Dr. Le Bon sent a quantity of meat slightly coated with them to La Plata, which they reached in as fresh a state as when they started from Paris.

A great deal has been said and written about the injurious effects of tobacco on the system, but these effects have been greatly exaggerated. There is no doubt that the excessive use of the weed is noxious, but its habitual employment in moderation is not so dangerous as anti-smokers endeavour to make out; for, when it is considered that about two-thirds at least of the inhabitants of the globe use tobacco in one form or other, there is every reason to believe that the charges against it are not quite justifiable. The bulletin of the Association Française against the use of tobacco contains a note by Dr. Piasecki, physician to the tobacco manufactory at Havre, on the effects of the weed on the women employed in the manufacture of cigars, &c. After a minute inquiry among the women of the establishment, 540 in number, Dr. Piasecki, has arrived at the following conclusions—that the manipulation of tobacco, even on such a large scale as is practised in the manufactory, had no pernicious influence on their general health, that they were not more subject to the maladies peculiar to their sex, nor was the mortality among them and their children greater than among women otherwise employed. Dr. Piasecki, however, adds, that a short time after their admission to the manufactory, the women generally complain of headache, giddiness, nausea, but they soon get accustomed to the work, and to the emanations of the tobacco, and continue their work without any further inconvenience.

Paris, October 24th, 1882.

AN AMERICAN CONVALESCENT HOME.

(*From a Roving Correspondent.*)

THE first convalescent institution ever established for hospital purposes in America was opened on April 25th, 1882. It was founded by Miss Mary Russell, to whose devotion it owes much of its success. It is called the Waverley Convalescent Home, and is worked by the trustees of the Massachusetts General Hospital. Waverley is about seven miles from Boston, the country around is hilly and well wooded, and the site selected for the convalescent home is a singularly beautiful spot. With all the progressive genius for which the Americans are famed, for some unexplained reason they have not heretofore recognised the advantages of convalescent hospitals. I shall have more to say of the Massachusetts General Hospital on another occasion, and so need not refer further to it here. The Waverley Convalescent Home has been erected from a fund of 100,000 dollars, which was specially raised for this purpose, 30,000 dollars being spent on the buildings and furniture, and 70,000 dollars being invested as an endowment fund for the permanent maintenance of the Home. It contains thirty beds for patients, and has two wards of nine beds each, one with three beds, two with two beds, and four single-bedded rooms. The Home is intended mainly for the use of the patients at the Massachusetts General Hospital, and both free and paying patients may be admitted. The proportion of accommodation for paying to free patients is about one to five; but as the object of the trustees is first to benefit the poor who are unable to pay the expense of procuring fresh air and change, so far none but free patients have been received. This is remarkable, and shows how easily the combined pay and free system works in the general hospitals of America. Although the majority of the patients treated in the Massachusetts General Hospital pay something towards the cost of their maintenance during their residence within its walls, the trustees enact that the Convalescent Home shall be for the minority—i.e. the poor; no pay patient is admitted, and no difficulty whatever arises. The whole arrangements at the Waverley Home are admirable, and the cheerful and cleanly appearance of everything fills the visitor with gratification. Every ward, every room, every office, from roof to basement, is admirably arranged and perfectly kept. Indeed, I have never seen a more model institution than the Waverley Convalescent Home.

The sanitary arrangements have been very carefully planned. The w.c.'s and slop-sinks are on a new and very simple but excellent plan, and might with advantage be introduced into English hospitals. The closet consists of a simple glazed earthenware hopper fixed upon an S-pipe placed upon a floor of glazed white tiles. No wood-work whatever is used except the seat, two seats being fixed with hinges, one on each side of the pan, so that the same closet serves for nurses and patients. The nurses' lid is raised, fixed to the side, and locked, except when in use. The slop-sinks are large and of galvanised iron, being two feet in diameter at the top, so that they serve as urinals when necessary; they are also fixed on a tiled floor. The partitions between the closets are of wood; they are placed six inches above the floor, the doors to the closets being one foot above the floor at the bottom and louvred throughout. Thus all parts of the closets and lavatories can be washed

out with ease, there is no accumulation of dust or dirt, and all pipes are exposed. The woodwork and doors throughout the home are of pitch pine varnished, and the furniture is made of the same wood. This, the first American convalescent home, is well worth a visit, and I have little doubt many others will soon be erected. The plans and arrangements reflect great credit upon Dr. Whittemore, the able superintendent of the Massachusetts General Hospital, whose knowledge of hospital administration and the zeal with which he enters into his work must prove invaluable to the trustees.

MEDICAL NOTES IN PARLIAMENT.

IN the House of Commons on Tuesday, on the motion of Mr. Dodson, the report to the President of the Local Government Board, by the inspectors appointed to inquire into certain deaths and injuries alleged to have been caused by vaccination at Norwich, was presented to Parliament. Captain Aylmer gave notice of a question as to the transport and commissariat arrangements during the Egyptian campaign.

On Wednesday, Sir R. Cross gave notice of two questions to the Home Secretary as to what steps are being taken under the Artisans' Dwellings Acts by the Metropolitan Board of Works and the Commissioners of Sewers of the City of London.

Mr. P. A. Taylor will inquire on Tuesday next of the President of the Local Government Board when the report of the Norwich vaccination inquiry will be in print.

Mr. Cochrane Patrick has given notice that next session he will call attention to the operation of the Factory Laws in Scotland.

Medical News.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—The following gentlemen, having passed the required examination, received the Diploma in Dental Surgery at a meeting of the Board of Examiners on Wednesday last:—

Ackland, John M'K., Exeter.
Albert, Henry Louis, Sloane-street.
Andrew, John James, Belfast.
Bate, Frederick William, Alexander-road.
Cornelius, William Fryer, Teignmouth.
Edwards, Richard, Pontdolgoch.
Gould, John Horace, Exeter.
Hughes, Morgan, Redhill.
Kissack, Frank Hill, Douglas, Isle of Man.
Royston, Jonathan, Douglas, Isle of Man.
Patterson, William Todd, Kingsland.
Tester, Alfred Horsee, Brighton.

One candidate was referred.

UNIVERSITY OF CAMBRIDGE.—The following Degrees have been conferred:—

M.D.—Charles Clement Lepage, Magdalen.
M.B.—John Grissell Marshall, Clare.

The under-mentioned have passed the examination for the Certificate in Sanitary Science:—

D. S. Davies, M.B.; A. Maclachlan, M.D.; C. J. McNally, M.D.; T. Maxwell, M.D.; C. J. W. Meadows, M.R.C.S.; A. Pern, L.R.C.P.; S. M. Saboman, M.D.; Joseph Smith, M.R.C.S.; W. E. Stevenson, M.B.; J. A. Thompson, L.R.C.P.; Henry Smith, M.B.

The following Examiners have been appointed for the ensuing year: For the First M.B. Examination—Messrs. Main, Garrett, and Vines; for the Second M.B. Examination—Dr. Watney, Dr. Shuter, and Mr. Marshall; for the Third M.B. Examination—Drs. R. E. Thompson, Galabin, and Handfield Jones. Messrs. Luther Holden and Thos. Bryant have been appointed Examiners for Medical and Surgical Degrees, and Dr. Cheadle Assessor to the Regius Professor of Physic, during the ensuing year.

COLLEGE OF PHYSICIANS IN IRELAND.—The following Member of the College has been elected to the Fellowship:— John Henry Chapman.

The following gentlemen have been admitted Members of the College:—

Walter Charles Bourney, William Dyas, Frederick Ffolliott, William Henry O'Meara, John Alexander Scott.

At examinations held during October the following candidates obtained the Licences in Medicine and Midwifery of the College:—

MEDICINE.—Henry Adcock, John Mary Harrington, Thos. Chatterton Hutchen, John Henry Jones, Claudius O'Donel, John Wm. White, William Henry Wright.
MIDWIFERY.—Henry Adcock, William Hallaran Bennett, John Mary Harrington, Claudius O'Donel, John William White.

At a special examination held in September the following gentleman obtained the Diploma in Midwifery:—

John William Williams.

The following office-bearers have been elected for the ensuing year:—President: W. Moore. Vice-President: F. R. Cruise. Censors: F. R. Cruise, Arthur W. Foot, Fleetwood Churchill, and C. J. Nixon. Additional Examiners: G. F. Duffy, J. Magee Finny, A. V. Macan, C. J. Nixon, J. M'Purser, and W. G. Smith. Registrar: John W. Moore. Treasurer: Aquilla Smith. Examiners in Midwifery: J. R. Kirkpatrick and Stephen M. MacSwiney. Professor of Medical Jurisprudence: R. Travers. Representative on the General Medical Council: Aquilla Smith.

APOTHECARIES' HALL.—The following gentlemen passed the examination in the Science and Practice of Medicine, and received certificates to practise, on Oct. 19th:—

Jackson, Paul, Torrington, Devon.
Schön, Charles Henry, Bridge, Canterbury.

The following gentleman also on the same day passed the Primary Professional Examination:—

Morgan, George, Charing-cross Hospital.

THE Poplar Hospital is to be opened for the reception of scarlet fever patients.

THE munificent legacy of £20,000 has been bequeathed to the Salop Infirmary by the late Mr. Henry Spence, merchant of Shrewsbury, who died on the 18th inst.

MR. THOMAS ASPINALL, L.R.C.P. Edin., of Over Darwen, has, we regret to learn, suffered serious injuries by being thrown from his trap.

THE Rowley Sanitary Authority have, in consequence of the prevalence of zymotic disease in the district, decided to provide an infectious disease hospital.

A MAN died last week in the Glasgow Infirmary from hydrophobia resulting from the bite of a rabid dog on March 14th last.

THE salary of Dr. Stevenson, medical officer of health for Paddington, has been increased from £300 to £400 a year.

THE balance of the proceeds of the recent Guild Festival at Preston amounts to £626, which it is proposed to hand over to the treasurer of the infirmary.

CHARING-CROSS HOSPITAL MEDICAL SCHOOL.—Mr. W. Morrison has obtained the first Entrance Scholarship of £30, and Mr. G. H. Biden the second Entrance Scholarship of £20.

THE foundation-stone of a new wing of the North-West London Hospital, in the Kentish-town-road, was laid on Tuesday by the Lady Mayoress. The subscriptions amounted to £285.

VACCINATION GRANTS.—The following gentlemen have received the Government grant for efficient vaccination:—Mr. W. Hood, M.R.C.S., L.S.A., City of York (second time); Mr. W. H. Hatfield, Hambledon District of the Droxford Union; and Mr. C. Lyddon, Oldbury.

A PLOT of land has been offered by the Hammersmith Burial Board to the Fulham District Board of Works for £873, on which to erect a mortuary, a coroner's court, and a post-mortem room for the district. The offer has been accepted.

HALIFAX MEDICO-CHIRURGICAL SOCIETY.—A meeting of the practitioners of Halifax was held at the infirmary on Monday, Oct. 23rd, for the purpose of forming a Medico-Chirurgical Society for Halifax and its district. The chair was taken by Dr. Bullin. It was resolved to inaugurate a Society having for its leading features the distribution of medical periodicals, and the monthly reading of short practical papers, with exhibition of specimens. There cannot be a doubt as to the social influences for good of local societies.

MANCHESTER SOUTHERN HOSPITAL.—The annual meeting of the subscribers to this institution was held on Monday last, the Mayor of Manchester presiding. The report stated that 176 in-patients had been admitted during the past year, 3536 out-patients (women and children) relieved, and 332 poor married women had been visited by the medical officers. The expenditure had been £955, which was very nearly met by the receipts (£947).

HOSPITAL SATURDAY FUND.—No less a sum than £160 has been received from the Royal Arsenal, Woolwich, towards this fund, of which £101 was contributed by the Laboratory Department alone. The total collection at the Arsenal last year amounted only to £90. The receipts from the Post Office are also considerably in excess of 1881, amounting in the aggregate to £286. The workshop collections are still coming in satisfactorily, and thus far both in number and amount are generally in advance of those of preceding years. The time fixed for the reception of these collections, admitting of their inclusion in the present year's balance sheet, has been extended to the 18th of next month. Between thirty and forty different hospitals and dispensaries have intimated their willingness to receive representatives of the fund at their respective boards of management as life governors.—*Times.*

ROYAL UNIVERSITY OF IRELAND.

M.D. DEGREE EXAMINATION.

(Sept. 18th, 1882.—9.30 A.M. to 12.30 P.M.)

ANATOMY.—(PASS.)

Section A.

1. Describe the nasal fossæ.
2. State precisely what are the relations of the right ureter in the male and female respectively.
3. Describe the necessary dissection to be made in order to expose the spheno-palatine ganglion.

Section B.

4. Describe the lymphatics of the inguinal region. Trace the course of the superficial and deep epigastric arteries, giving the relations and branches of the latter.
5. Give the boundaries of the fourth ventricle, and mention all the parts observed on its floor. What is the ligula?
6. Describe the arytenoid cartilages, and the ligaments connected with them.

(This examination comprised, besides, a dissection with an oral on the dead body and an oral on osteology.)

ANATOMY.—(HONOURS.)

Section A.

1. Describe a dissection that will bring into view the malleus, incus, and stapes in position. (No description of parts is required.)
2. Give a detailed account of the movements of the knee-joint.

Section B.

3. Describe the intrinsic muscles of the tongue.
4. Give the position and vascular and nervous connexions of the coccygeal gland. Describe its appearance, size, and structure.

(Also a dissection and oral on the dead body, &c.)

Medical Appointments.

Intimations for this column must be sent DIRECT *to the Office of* THE LANCET *before 9 o'clock on Thursday Morning at the latest.*

APPLEFORD, S. HERBERT, M.R.C.S., has been appointed a House-Physician at the London Hospital.

BADDELEY, CHAS. EDW., M.B.Lond., M.R.C.S., L.S.A.Lond., has been appointed Medical Officer for the Gnosall District of the Newport (Salop) Union.

BARLOW, THOS. CAREY, L.R.C.P.Ed., has been appointed Medical Officer to the Third District of the Hackney Union.

CLENDINNEN, J. GEORGE, L.R.C.S.I., L.A.H.Dub., has been appointed Medical Officer of Health for the Lower Sedgley Urban Sanitary District, vice Eagleton, resigned.

CROSS, FRANCIS RICHARDSON, M.B.Lond., F.R.C.S.Eng., has been appointed Honorary Surgeon to the Bristol Eye Hospital, vice Bartley, deceased.

EASON, ALEXANDER M., L.R.C.P.Ed., L.R.C.S.Ed., has been appointed Medical Officer to the Talbot Clifton Friendly Society, and the Order of Druids, Lytham, vice William E. Pountney, M.D., resigned.

FERRIS, JOHN SPENCER, M.B., L.R.C.P.Lond., M.R.C.S., L.S.A.Lond., has been appointed Medical Officer for the Denham District of the Eton Union.

FINLAY, Rev. HUNTER, M.D., L.F.P.S.Glas., has been appointed Surgeon to the Hodgkinson District Hospital, Queensland.

GALE, A. K., M.R.C.S., late House-Surgeon to the London Hospital, has been appointed Assistant Medical Officer to the Fulham Fever Hospital.

HAYCROFT, CHARLES H., M.R.C.S., L.S.A.Lond., has been appointed Medical Officer for the Bow District of the Crediton Union.

KNIGHTS, Mr. JAMES WEST, has been appointed Public Analyst for the County of Huntingdon.

MACCARTHY, FFENNELL, M.B., B.Ch. Univ. Dub., has been appointed Surgeon to the Midland Railway, Worcester District, vice Geo. F. A. Knapp, M.R.C.S., deceased.

MACDONALD, ALEXANDER, L.R.C.P.Ed., L.R.C.S.Ed., has been appointed Medical Officer for the Kirkoswald District of the Penrith Union.

MACGILLIVRAY, CHARLES WATSON, M.D., F.R.C.S.E., has been appointed Assistant-Surgeon to the Royal Infirmary, Edinburgh.

PENRUDDOCKE, CHARLES, M.R.C.S., L.R.C.P.Ed., has been appointed Medical Officer to the Vale District of the Winchcombe Union, vice Thos. Newman, M.R.C.S., L.S.A.Lond., deceased.

PRATT, JAMES, M.R.C.S., has been appointed Resident Medical Officer to the St. George, Hanover-square, Dispensary, vice F. Prince, M.R.C.S., resigned.

REYNOLDS, JAMES J., L.R.C.P.Lond., M.R.C.S., L.S.A.Lond., of Stoke-by-Clare, Suffolk, has been appointed Assistant-Surgeon to the Portland Convict Prison.

RYAN, JOHN, L.K.Q.C.P.I., L.R.C.S.I., has been appointed Medical Officer for the Second District of the Northleach Union.

THISTLE, FREDERICK T., L.R.C.P.Lond., M.R.C.S., has been appointed Senior House-Surgeon to the Torbay Hospital and Provident Dispensary, Torquay.

WILEY, ARTHUR ORMSBY, L.R.C.P.Ed., L.R.C.S.I., has been appointed Medical Officer for the Scriven District of the Knaresborough Union.

Births, Marriages, and Deaths.

BIRTHS.

ALLEN.—On the 12th inst., at Brunswick-terrace, Freeman-street, Grimsby, the wife of T. W. J. Allen, L.R.C.P.Lond., M.R.C.S.Eng., of a daughter.

ALLEN.—On the 20th inst., at Uxbridge-road, Shepherd's-bush, W., the wife of Thomas Allen, Surgeon, of a daughter.

BEVERIDGE.—On the 16th inst., at Dart Villa, Totnes, the wife of H. T. S. Beveridge, M.D.Edin., Staff-Surgeon, Royal Navy, of a daughter.

HUTCHINSON.—On the 29th August, at St. Kilda, Melbourne, Australia, the wife of B. C. Hutchinson, M.D., of a son.

JONES.—On the 14th inst., at North-park House, Harrogate, the wife of A. O. Jones, M.D., of a son.

MACNALTY.—On the 16th inst., at Colton Old Vicarage, Greenodd, Ulverston, the wife of Frank C. MacNalty, M.A., M.D. Dub. Univ., of a son.

RAVEN.—On the 19th inst., at Broadstairs, the wife of Thos. F. Raven, L.R.C.P., of a daughter.

SMITH.—On the 23rd inst., at Phillimore-terrace, the wife of W. Towers Smith, M.R.C.S., of a son.

MARRIAGES.

BOTHAMLEY—SMITH.—On the 14th inst., at St. John's, Lewisham High-road, R. Broughton Bothamley, M.R.C.S., of Bromley, Kent, to Jeannetta Harrison, daughter of the late William Smith, of Southwark.

BULLOCK—SULIVAN.—On the 14th inst., at Holy Trinity, Bournemouth, Henry Bullock, F.R.C.S., of Overtown House, Spring Grove, Isleworth, to Sophia Henrietta, eldest daughter of Admiral Sir B. J. Sulivan, K.C.B., of Tregew, Bournemouth.

KENNEDY—HAYLE.—On the 17th inst., at St. Mary's, Rochdale, William A. Kennedy, M.B., L.R.C.P.Lond., son of the late Dr. J. F. Kennedy, of Newcastle-on-Tyne, to Sarah, third daughter of Thomas Hayle, M.D.Edin., of Rochdale.

POPE—PECKHAM.—On the 25th inst., at the Parish Church, Pinner, by the Rev. J. S. Lyon, assisted by the Rev. Dr. Pinnock, Vicar, Percy Pope, M.R.C.S., L.R.C.P., of Owston Ferry, Lincolnshire, youngest son of the late John Robinson Pope, M.R.C.S., L.S.A.Lond., of Woodridings, to Kate Florence, fourth daughter of the late Robert Peckham, Solicitor, of Doctors' Commons, and of Tottenham.

DEATHS.

ANDERSON.—On the 22nd inst., at Hillingdon Heath, Uxbridge, William Alexander Anderson, M.D.Aber., F.R.C.S.Eng.

BROUGHTON.—On the 14th inst., at Ambleside, Francis Broughton, F.R.C.S., late of Her Majesty's Medical Service, Bombay, aged 62.

EDWARDS.—On the 13th inst., at his residence, Stony-hill, Colebrookdale, Shropshire, Benjamin Edwards, M.R.C.S., L.A.C., last surviving son of the late William Edwards, M.R.C.S., of Colebrookdale, aged 67.

HOLLIS.—On the 19th inst., at his residence, Alvaston, near Derby, William Hollis, Surgeon, aged 76.

PEARCE.—On the 5th inst., at Cadiz, of consumption, George A. C. Pearce, M.B., F.C.S., late of Dane's-inn, London, and Lee, Kent, aged 31.

WATERHOUSE.—On the 17th inst., at Peating Magna, Leicestershire, of enteric fever, Joseph Bourne Waterhouse, M.R.C.S., in his 30th year.

N.B.—*A fee of 5s. is charged for the insertion of Notices of Births, Marriages, and Deaths.*

METEOROLOGICAL READINGS.

(Taken daily at 5.30 a.m. by Steward's Instruments.)

THE LANCET OFFICE, Oct. 20th, 1882.

Date.	Barometer reduced to Sea Level and 32° F.	Direction of Wind.	Dry Bulb.	Wet Bulb.	Solar Radia in Vacuo.	Max. Temp. Shade.	Min. Temp	Rain fall.	Remarks at 5.30 A.M.
Oct. 20	29·82	S.	47	47	..	62	45	·41	Overcast
,, 21	29·61	S.	53	52	..	57	41	·10	Raining
,, 22	29·25	S.W.	53	51	..	55	47	·33	Raining
,, 23	29·51	W.	46	43	..	56	39	·17	Bright
,, 24	29·19	S.E.	46	45	..	58	41	·33	Raining
,, 25	29·55	W.	44	43	..	53	37	·22	Foggy
,, 26	29·56	S.E.	41	40	..	53	35	..	Foggy

Notes, Short Comments, and Answers to Correspondents.

It is especially requested that early intelligence of local events having a medical interest, or which it is desirable to bring under the notice of the profession, may be sent direct to this Office.

All communications relating to the editorial business of the journal must be addressed "To the Editor."

Letters, whether intended for publication or private information, must be authenticated by the names and addresses of their writers, not necessarily for publication.

Lectures, original articles, and reports should be written on one side only of the paper.

We cannot prescribe, or recommend practitioners.

Local papers containing reports or news-paragraphs should be marked.

Letters relating to the publication, sale, and advertising departments of THE LANCET *to be addressed "To the Publisher."*

A MUCH NEEDED IMPROVEMENT.

GREAT inconvenience is experienced by ladies in London by the absence from our streets of any sort of accommodation for them similar to that to be found in every principal thoroughfare for the use of gentlemen. With the exception of railway stations and a very few of the better class restaurants, no facilities are provided of the kind referred to for females, and any movement for supplying the deficiency is worthy of support. Such a movement is now on foot, promoted by Mrs. Emily Wilcox, of 180, King's-cross-road, who will be glad to receive subscriptions in aid of the scheme. This lady proposes to open an experimental retiring-room in the neighbourhood of King's-cross first, and, as the funds flow in, to increase the number by providing them at all crowded spots. The use of these places is to be open to all without charge, but a box will be provided in each for the reception of gratuities towards defraying the expenses. The scheme is a deserving one, and ought not to have been left to private enterprise by the parochial authorities. Probably, however, when once provided, the expense of keeping the rooms in a fit state for use will be undertaken by the local governing bodies. On hygienic grounds alone the proposal is deserving of success.

Kent.—F. H. Whymper, Esq., Factory Department, Whitehall.

A CASE OF COMPLETE INVERSION OF THE UTERUS.

To the Editor of THE LANCET.

SIR,—The above is an accident which occurs so infrequently as to be worth a passing notice. I was called at 6.40 on Saturday morning, the 15th October, to see a married woman, aged twenty-six years. This was her third confinement. The child was born at half-past five, very rapidly. She was being attended to by a midwife, and I was sent for because there was something wrong about the after-birth. On my arrival I found the woman lying on her back on the floor, perfectly exsanguine and collapsed, and without pulse. The placenta was attached exactly in the centre of the fundus of the uterus, and it, still adherent, along with the whole of the uterus, lay between the legs of the woman; and the bed and clothes were completely saturated with blood. I peeled off the placenta, replaced the uterus, and tried to rally the woman, but she died from shock and hæmorrhage ten minutes after my arrival.

The history was as follows:—The woman was very anæmic; had a rupture of the perineum at her first labour; the midwife had pulled at the cord to separate the placenta from the uterus; and this last, along with the central position of the attachment of the placenta, which was firmly adherent, and the rupture of the perineum, had probably caused the complete inversion which I found.

I am, Sir, yours, &c.,

Crawshawbooth, Manchester, Oct. 1882. J. L. KERR, M.B., &c.

"A QUERY."

DR. PRATT, in reference to a note which appeared under this heading in our issue of Oct. 14th, writes to say that the cause of the discolouration referred to has been found to be an ointment used by the patient which was not official, and the composition of which was not known until after the note appeared in THE LANCET. This ointment produced a copious ink stain, which has disappeared from the dressings since the unguent has been discontinued.

Manchester should consult Mr. Burdett's book on Cottage Hospitals, published by Messrs. Churchill.

"THE USE OF TOBACCO."

To the Editor of THE LANCET.

SIR,—Having been a regular and moderate, never at any time immoderate, smoker for the past twenty-five years, and having closely observed the effect of tobacco upon myself, you may possibly think the impressions I have formed worth recording. Even as a student I never smoked during the day, and have for seventeen or eighteen years smoked nothing but Cope's "mild Havannah" out of a briar-wood pipe, which I have frequently cleaned or changed. I should estimate my average is about four pipes of medium size every evening between 9 and and 11 o'clock; cigars or cigarettes I rarely smoke. I consume five pounds of tobacco a year. About four years ago I began to suffer from severe nasal catarrh, which in a few months completely destroyed my sense of smell. I have not since then been able to smell or taste the smoke in the slightest degree. This misfortune has lessened my pleasure of smoking very much, and taken away much of the desire for it; but I still feel that I have missed something if I do not smoke at least one evening pipe.

Now, as to the effect of tobacco on the system. I am perfectly certain that it is the man with abundant nerve power who most keenly enjoys his pipe and is least harmed by it. The weary, the anxious, the worried do not enjoy or resort to smoking for the pleasure they derive, but for the tendency to tranquillisation and sleep they find it produces; in other words, it allays nervous irritability and diminishes the desire to energise. It has been stated that under its influence the heart's action becomes stronger. This is undoubtedly the case, but how is it explained? I think by the temporary disturbance of innervation by its action on the cardiac branches of the vagus. Three or four pipes of Cavendish tobacco would produce in me the irregular bounding of "tobacco heart," and cause me to wake up with a terrific nightmare. Here is increased action with irregularity of rhythm, but with depression the following morning. It has also been said to promote digestion. The after-dinner or luncheon pipe, so commonly taken, shows that it does so—but how? I think by tending to cause, by its effect on the controlling nervous influence, a more copious and immediate flow of gastric juice, and probably increasing the movements of the stomach, as undoubtedly it does that of the intestines, for thousands of men will tell you that a pipe after breakfast helps them in this respect without fail. Smokers to excess generally become of pale or sallow complexion, and occasionally of a slightly jaundiced hue; they are lethargic often in mind as well as body. This points to permanently lowered heart power, and as an example of its more immediate depressing influence following quickly on the transient period of "increased force," I may quote the case of an innkeeper, aged eighty-one, who was in the habit of beginning his evening smoke about 6 in the evening. During the year 1879 I was hastily summoned to him about 9 at night at least half a dozen times in consequence of his having fallen off his chair in a fainting fit. On each occasion he had quite recovered before I got to him. I found the cause clearly to be the effect of tobacco, and I persuaded the old man to puff at an empty pipe, which he did, and had no more syncope. To sum up, I am certain that the toxic effect of tobacco is to lower the nervous power, and, as a consequence, impair the circulation. It also tends to produce heavy lethargic sleep, which is followed by a disinclination to rise, and a feeling of weariness and low spirits, which the usual cold sponging tends to remove. The conflicting views held regarding its influence and effects are due, I feel sure, to the diverse symptoms it produces in different diatheses and temperaments and at different ages. I have met numerous cases, and am an instance myself, that in middle life men begin to feel that they cannot smoke as they formerly did, and they begin to limit themselves. Why is this? I think it is because as age advances we lose that large reserve of nervous power which in youth enables us to do much that we cannot do with impunity in middle life, and thus the depressing effect of tobacco is unfelt in the days of exuberant and rapidly restored nerve power. I am speaking throughout, be it remembered, of strictly moderate smoking, for no one doubts the evil effects of excess.

If further proof be needed of the depressing effect of tobacco on the nervous centres, witness the almost immediate result when a half-drunken man smokes. It rapidly renders him helpless and more incoherent. Here I believe the nervous centres, already to a great extent paralysed by the alcohol, are very susceptible of the influence of tobacco. It has often occurred to me that the desire to drink stimulants, which undoubtedly accompanies the use of tobacco, is due as much to the nervous depression giving rise unconsciously to the feeling of need for stimulation as to the dryness or irritation of the mouth and fauces produced by the deposit of oil from the smoke. In this respect I regard tobacco as undoubtedly productive of much harm, as when using it the provocation to drink beer or spirits is certainly increased.

I remain, Sir, yours obediently,

October, 1882. DELTA, M.D.

NEW SYSTEM OF DROP-MEASURING.

A NOVELTY in pharmaceutical appliances has been patented by H. Lamprecht, of Marienhütte (Hanover), in the shape of a drop-measuring bottle, which is specially constructed for that purpose. A leading German paper connected with the glass trade remarks that experiments made show that even with different ways of sloping the bottle, the drops are almost exactly equivalent in quantity.

L.R.C.P. Lond.—Some time ago it was stated that the German Chancellor had caused the announcement to be made that Duke Theodore of Bavaria, who had then taken the degree of Doctor of Medicine at a German University, had received a certificate enabling him to practise as a surgeon without being required to undergo the additional examination to which intending practitioners are ordinarily liable under the German law.

TRICYCLES.

To the Editor of THE LANCET.

SIR,—Now that tricycles are happily coming so much into use, I will endeavour, through the medium of your valuable journal, to convey to my brother practitioners the result of my experience, which has extended over a period of upwards of ten years. Having made affections of the nervous system my pet study for many years, I have had much opportunity of testing the value of the tricycle, and I can confidently say if practitioners would give the subject their consideration, they will agree with me in regarding the machine as a remedial agent of great value. Cases are continually coming under our notice which require, in addition to medical treatment, exercise in the pure, fresh air, by which the brain and nervous system become invigorated, and the sufferer is relieved from that irritable feeling which can only be understood by those who suffer from it; and need I also say by this means the general muscular system is strengthened, including a vast number of muscles which are not called into action by the ordinary walking exercise. This fact is borne out by tricycle riders, who declare they can walk much better than they could before they took to tricycle riding. Of course I am fully aware walking exercise is exceedingly good—quite in accordance with nature's laws in a vast number of cases, but I have generally found those of my patients who try to walk frequently complain of much weariness and exhaustion, which is no doubt attributable in a great measure to the fact of the mind not being diverted, as in the case of horse or tricycle-riding. Some time since one of your correspondents called attention to the tendency in those who use this kind of locomotion to contraction of the chest by leaning forward on the handles of the machine. This is chiefly confined to timid and inexperienced riders; nevertheless it should be remedied, and this can easily be done by having the handles of the tricycle put further back. The effect of this modification may be easily tested by sitting in one's chair in the same position as on the tricycle, placing the hands under the seat and drawing them back, which will bring the body into an erect posture, and throw the shoulders back and the chest forward. I propose to bring this point under the notice of the makers, with suggestions how to effect the improvements indicated. As to the question of the advisability of females riding tricycles, though at first I entertained serious doubts on the matter, I have from experience come to the conviction that females need have no fear; on the contrary, some who have long suffered from internal troubles have derived much benefit from this mode of exercise, especially in the class of cases where the system has fallen below par by long continued confinement. Again, with regard to the tendency of tricycle-riding to produce hernia, in no instance has it done so under my observation. Indeed, a gentleman who for many years had suffered from very large double inguinal hernia tells me he owes his present good health to this form of exercise, and does not feel the least inconvenience from his affliction, and although advanced in life he continues his daily rides, wet or fine, and has up to the present time ridden very considerably above 50,000 miles. Riders should not attempt too much at once, but steadily continue the daily use of the machine, and by degrees, as the muscles develop themselves and the nerves get tone, they will find all difficulties pass away. In concluding, I would advise intending riders to try various machines before purchasing, and judge for themselves.

I am, Sir, yours, &c.,

Oct. 1882. ONE WHO ADVOCATES EXERCISE IN THE PURE AIR.

Bookworm.—1. Walshe (Lungs and Heart), Hayden (Heart), or Balfour (Heart).—2. W. Roberts, Dickinson, or Grainger Stewart.—3. Hammond, Buzzard, or Althaus.

TEMPERATURE AT SAN REMO.

To the Editor of THE LANCET.

SIR,—I enclose a report of the weather and temperature here for the week just finished, which may be interesting to some of your readers.

I am, Sir, yours faithfully

L. E. KAY SHUTTLEWORTH.

Villa Caleagno, San Remo, Italy, Oct. 22nd, 1882.

	Maximum.	Minimum.	Difference.	Temp. 8.30 A.M.
Mean for the week ..	65° ..	52° ..	13° ..	57°
Highest on any day ..	68° ..	55° ..	13° ..	59°
Lowest on any day ..	63° ..	49° ..	14° ..	55°

Two days cloudless, four bright sun and light clouds, two marked almost cloudless, one cloudy. No rain fell this week, and the wind was very light—sometimes none could be felt.

SWISS FACTORY LEGISLATION.

ACCORDING to the report of the Swiss factory inspectors, the cantonal authorities of Glarus issued directions last year to the factories within their jurisdiction, that all accidents which cause more than six days' absence from work on the part of the person injured should in future be notified to the authorities. The object of this regulation is stated to be the frustration of attempts which are sometimes made to keep accidents from the knowledge of the officials, whose duty it would be to make an investigation into the circumstances.

Mr. W. J. Masson.—In almost every number of THE LANCET during the last two years some observation has been recorded of the association of acute specific diseases with organisms, but the causal relation has been proved in very few instances, although probably, by analogy, in all. It has not yet been proved in the case of scarlet fever.

TRIAL BY JURY.

To the Editor of THE LANCET.

SIR,—May I ask you to give publicity to the following case, in the interest of the unfortunate victim.

Mrs. Dodsworth was arraigned at the Winchester Sessions, held on the 17th inst., on a charge of having taken poison at Bournemouth, on July 25th, with intent to injure herself. There was no defence, the defendant, who is an old woman over seventy, never asking a question. The case was clearly proven, and the magistrate, in summing up, concluded:—"You have now to determine whether this poor woman took the poison with the intent of doing herself grievous bodily harm," or words to that effect. After a few minutes' consultation, the foreman declared that they had come to an opinion, but they would like to add a rider. They were told to give their verdict first. Verdict was accordingly given, "Guilty." Now for the rider: "But we think she did not know what she was doing." The magistrate here remarked that if that was their opinion they should have given a verdict of not guilty, "but," he added, "there has been no evidence whatever brought to show you that she was of unsound mind; however, the doctor is in court, would you like to ask him any questions?" "Oh, I come from Bournemouth!" exclaimed a juror, and this appears to have been convincing, for, without more ado, a verdict of "Not Guilty, on the ground of insanity," was returned. The prisoner was, therefore, informed that she would be detained during Her Majesty's pleasure, and was removed in tears.

Now, the facts of the case are briefly these:—Mrs. Dodsworth has been living in Bournemouth for some months, having been placed by friends under the care of a woman who rents a house in a poor neighbourhood. She is, I think, over seventy years old, and has been in very good circumstances, rich and well connected. Of this I am assured by people who have known her friends in York. She has been much weighed down by the change in her affairs, has become peevish, and, it is said, addicted more or less to drinking. These things, added to her habit of dwelling on her former circumstances, and her eccentric costume of faded finery, have no doubt led to the opinion held by the poor people among whom she lived, and subsequently by the jury, that she was of unsound mind. But such I am sure is not the case, for I have attended her here and at her house for some time, and though I have seen that she is of weak intellect, yet she has always been quite mistress of her deeds, and always able to go about and collect recommendation-tickets to ensure her attendance, &c. At the time she attempted her life she had been depressed by having to leave her lodgings and other circumstances, but her subsequent conduct was perfectly rational. She submitted readily to treatment, merely saying in excuse, "I wanted to go to Heaven."

What I wish to point out is that in the mistaken idea that they would be doing a kindness, the jury have condemned this poor old woman to pass the remainder of her life in a lunatic asylum, whereas had they returned a verdict of guilty, the magistrate, taking into consideration that she had been already kept in prison nearly three months, would probably have let her off with a short additional term of imprisonment. Trusting that, by thus giving the case publicity, something may yet be done to alleviate her fate,

I remain, Sir, yours sincerely,

G. S. MAHOMED.

Bournemouth Dispensary and Cottage Hospital, Oct. 23rd, 1882.

Freshman should apply to the Secretary of the College for the details. The regulations are in force.

Dr. Newham.—We congratulate our correspondent on the *dénouement*.

"BELLADONNA POISONING."

To the Editor of THE LANCET.

SIR,—Let me add a case of the above, not the result of accident however. When I was a resident physician's assistant at the hospital, we had a very intractable case of sciatica, and the physician in charge determined to try the subcutaneous injection of atropiæ sulph. The amount given was one-eighth of a grain, a friend of my physician stating that he had on several occasions administered that amount, with no ill-consequences, and with uniform success. Our patient's symptoms consisted of dilated pupils, thirst, dryness of fauces, frequent desire to pass water, with a lively delirium. These all passed off without treatment in about eight hours, leaving the patient cured of his sciatica. We all resolved to try a little less atropia next time.

I am, Sir, yours truly,

Oct. 22nd, 1882. G. G.

THE DERIVATION OF THE WORD "DRUGGIST."

A GERMAN CONTEMPORARY calls attention to the fact that this word can be traced to the root "trocken," which signifies in German "dry." The same derivation is ascribed to the equivalents of the word in various European languages.

Enquirer.—Dr. William Woods Bradshawe was an old member of the College of Surgeons. He was subsequently elected a Fellow of the College, and, we believe, was Mayor of Reading. His widow left £1000 each to the Royal Colleges of Physicians and Surgeons, and Sir James Paget is the first appointed Bradshawe Lecturer at the College of Surgeons.

Forceps.—*Never* is practically for all time, and A would "never" be justified in practising in the town or neighbourhood without B's consent.

POISONING BY SHELL FISH.

To the Editor of THE LANCET.

SIR,—I enclose the notes of a case which recently occurred in my practice, and which may be of interest to some of your readers.

On Monday evening I received an urgent message to attend at once on a family in this village who had been taken seriously ill after having tea. The messenger informed me that they had all (herself included) partaken freely of crab, and had been taken with similar symptoms, which only varied in intensity. On arrival I found four sufferers, three of whom were ghastly pale, the fourth being the mother, who was fast recovering. Two daughters and the son were suffering most severely, the symptoms presented being great pain at the epigastrium, and violent vomiting, which was at first incessant, consisting of frothy mucus and particles of the fish and other contents of the stomach. The skin was cold and clammy, pulse very feeble, and in the son scarcely perceptible, as well as in the oldest daughter. The face was covered with a cold sweat, and the two latter cases seemed quite exhausted. Purging was not present. The other daughter did not seem so much affected, although she vomited freely. The treatment I adopted was the giving of carbonate of ammonia in ten grain doses, hot-water bottle to the epigastrium and to the feet, with a mustard-plaster to the calf of the legs, and enveloping in blankets and putting them all to bed. The vomiting only recurred twice afterwards in the son and once in the oldest girl; not at all in the other cases. They slept fairly during the night. Next morning, with the exception of feeling weak, they did not seem any the worse. The patients being adults, it struck me whether the case would have ended so satisfactorily in children.

I am, Sir, your obedient servant,

Great Ayton, Yorkshire, Oct. 17th, 1882. P. A. R., L.S.A. Lond.

L. D. S.—The examination for the Licence in Dental Surgery has just concluded. The calendar of the College of Surgeons contains the names of 510 licentiates in dental surgery.

Minimo Minor.—We fear our correspondent has no legal claim to a pension.

Mr. Aston Ayres and *An Old Practitioner.*—The matter shall have attention.

THE INTRA-VENOUS INJECTION OF FLUID IN SEVERE HÆMORRHAGE.

To the Editor of THE LANCET.

SIR,—In reply to Mr. Jennings I beg to state that I do not use the obstetric syringe for any of the purposes named in his letter. The perchloride of iron may be applied at least as effectively with a sponge, and, consequently, had not the idea of its having been so used in my mind. Water, salt, and brandy would, I believe, answer quite as well as Mr. Jennings's formula, and these things possess the great advantage of being always at hand. By care the entrance of air might be prevented, and the uniformity of the current insured. If however, the syringe has been so used, and unprovided with another, an ordinary glass one, which could be obtained at any druggist's, would do quite well. It is highly desirable that the appliances of our art should not be unnecessarily multiplied, and that the mind should be furnished with ready methods for emergencies. I am, Sir, yours faithfully,

Leeds, Oct. 23rd, 1882. PHILIP FOSTER.

D. S. J.—The Hunterian Oration will be delivered in February next, by Mr. Spencer Wells, the President of the College. Dr. Matthew Baillie, one of the executors of John Hunter, died Sept. 23rd, 1823.

Psychologist.—By reference to the general index of Boswell's Life of Johnson, it will be found that Dr. Thomas Arnold wrote on Insanity.

A Puzzled Practitioner and *F. C.*—No card enclosed.

INUNCTION IN SCARLATINA.

To the Editor of THE LANCET.

SIR,—For a considerable time I have used free rubbing-in of camphorated oil in every case of scarlatina which I have treated, during the eruptive stage as well as during peeling. I was congratulating myself on the results, when a medical friend of considerable experience expressed to me his opinion that this use of oil has a bad effect upon the kidneys. If you, or any of your readers, can throw any light upon the question thus raised it will confer a favour, which will be much valued.

I am, Sir, yours faithfully,

October 25th, 1882. CUTIS.

A COLONIAL SURGICAL APPOINTMENT.

WE are asked to state that the office of resident surgeon of the Provincial Hospital at Port Elizabeth, Cape Colony, has been filled up by the appointment of a colonist.

Student (Galway).—The International Scientific Treatises of Messrs. King and Co., London, would probably include some that would suit our correspondent. Any bookseller would procure a list for him from Messrs. King and Co. (Rex and Co.), Gracechurch-street, London.

SURGICAL CURIOSITY.

To the Editor of THE LANCET.

SIR,—An interesting case came under my notice about five weeks back. While examining the out-patients at the Stanley Hospital, a youth of twelve appeared with a tumour the size of a small marble, situated in his auricular lobule, just below the antitragus. I took it to be an ordinary cyst, despite the unusual site, and at once proceeded to remove it. This was easily accomplished, and on making an incision into it afterwards I discovered, in addition to some albuminous fluid, a grain of corn firmly embedded in a second cyst, which was attached to the internal aspect of the first. Five years previously the lad cut his ear on the site of the tumour. It healed in the usual way, and until two years back nothing disturbed it. From that time he noticed a small, pea-like body in the lobule, which thence described the usual symptoms accompanying the growth of a cyst. This case is interesting as a surgical curiosity, being I believe unique.

I am, Sir, yours sincerely,

ROBERT JONES, M.R.C.S. Eng.

Nelson-street, Great George-square, Liverpool, Oct. 20th, 1882.

Mr. Matthew Hunter.—Thanks. Our arrangements in the matter are, however, for the present complete.

Student.—The instrument is, and we should think must always be, untrustworthy.

R. W. W.—It would have no effect as regards its physiological action.

DEFORMITY OF THE FOOT.

To the Editor of THE LANCET.

SIR,—The particulars of the following case may be interesting, as it is, I believe, an unusual deformity, and serves to illustrate, perhaps, our origin from a lower scale.

I was called to see a female child, born the previous day; on examining the child I found the right leg was about an inch and a quarter shorter than the left, the shortening being more marked in the tibia than the femur. The two outer toes were absent, as well as the metatarsal bones and, I believe, the cuboid; there was no external malleolus, but there appeared to be a head to the fibula, and the fibula then seemed to taper downwards until it was lost by, I believe, anchylosis in the tibia. The tibia was raised up and generally thickened at about the junction of the middle with the lower third, like a badly-united fracture, and the skin at this point was puckered in, as though there had been a compound fracture. The foot was turned outwards, the malleolus projecting very much, giving the foot the appearance of flat foot. I could obtain no family history of deformity, or of any fright during pregnancy. The child was otherwise healthy.—I am, Sir, yours &c.,

D'ARCY SUGDEN, L.R.C.P. Lond.,

Resident Surgeon, Maryborough Hospital, Queensland.

Oct. 25th, 1882.

W. W.—We are not acquainted with a work specially devoted to the subject. It has, however, been discussed from time to time in our columns, and will probably be referred to again in our next issue.

Rev. J. W. Elliott.—We recollect no later deliverance on the subject than that of Dr. Poore in the Bradshawe lecture in September last year.

Mr. J. P. Pye.—We regret that we have not space for more letters on the subject.

HAMMAMELIS VIRGINICA.

To the Editor of THE LANCET.

SIR,—Can you or any of your readers inform me if there is any formula for the preparation of the tincture of hamamelis virginica; also, if they have tried the tincture as an injection for piles, if it is painful or successful. I am, Sir, yours truly,

October 25th, 1882. C.

*** Several letters respecting this drug appeared in THE LANCET of August 30th, 1879.—ED. L.

Alumnus should write to the Secretary of the College for the regulations concerning the prize. Only members, however, can compete.

Mr. Aubrey Wicks.—There does not appear to be any novelty in the suggestion.

POSTAL MICROSCOPICAL SOCIETY.

To the Editor of THE LANCET.

SIR,—I should be glad if any of your readers could inform me through the medium of your columns whether the above named society is still in existence. If it is, I should be glad to join it.

I am, Sir, yours &c.,

October 25th, 1882. HISTOLOGIST.

POPULATION OF EUROPEAN CITIES.

ACCORDING to a comprehensive statistical return lately published in Germany, there are in Europe 92 cities with more than 100,000 inhabitants, out of which four capitals show each over a million population, as follows:—London, 3,832,440; Paris, 2,225,910; Berlin, 1,122,500; Vienna, 1,103,110. Out of the 92 cities and towns alluded to, England claims 26, Germany 16, Italy 11, France 10, and Russia 8. The others are divided amongst the smaller states.

ERRATUM.—In our article of the 7th inst. on the treatment of the sick and wounded in Egypt, the name of Mr. Harrison, Surgeon of the Grenadier Guards, was erroneously given as Gardner.

COMMUNICATIONS not noticed in our present number will receive attention in our next.

COMMUNICATIONS, LETTERS, &c., have been received from—Professor Acland, Oxford; Mr. Campbell, London; Dr. Spencer Thomson; Mr. Hawkins-Ambler, Leeds; Mr. Hunter; Mr. Neville Stephen, Marseilles; Mr. Duncan Miller, London; Mr. Farren, Carnarvon; Dr. Philip Foster, Leeds; Mrs. Wilcox, London; Mr. Shuttleworth, San Remo; Mr. Mason, Herne-hill; Mr. W. Thomson, Melbourne; Mr. Courtenay, Victoria; Mr. Wheeler; Brigade-Surgeon MacDowall, Deesa; Mr. Charles Mills, London; Dr. Ross; Mr. Isaac Williams, London; Mr. Deane; Dr. H. Rayner; Mr. J. C. Lucas, Ahmedabad; Mr. H. Rogers-Tillstone, Brighton; Mr. Walter Rivington, London; Mr. Peach, Bath; Mr. Brown, New Wandsworth; Mr. Luke, Calcutta; Mr. Hall; Mr. Unsworth, Liverpool; Messrs. Evans and Co., Liverpool; Mr. Tomlins, Rugeley; Messrs. Woolley and Co., Manchester; Mr. Roper, Croydon; Mr. Kirkpatrick, Woodbridge; Mr. Quinton, Norwich; Mr. Storey, Cheltenham; Dr. Brodie, Wickham Market; Mr. Horne, Scarborough; Mrs. Chatty, Dawlish; Mr. Maddox, London; Dr. Percy Boulton, London; Dr. Mackintosh, Chesterfield; Dr. Henderson, London; Mr. W. G. Balfour, Walton; Mr. T. Dolan, Halifax; Mr. Dacre Fox, Manchester; Dr. Herbert Stowers, London; Mr. Symonds, Oxford; Dr. Wortabet, Beyrout; Mr. Ayres, Brighton; Dr. Pye, Galway; H.; Medicus, Shrewsbury; R. W. W.; Forceps; Kent; Delta; Student; Bookworm; L.R.C.P. Ed.; Theta, Dundee; An Old Practitioner; Glasgow; G. G.; W. W.; D. M., Manchester; Cutis; C.; Minimo Minor; &c. &c.

LETTERS, *each with enclosure*, are also acknowledged from—Mr. Smith, Ealing; Mr. Woodcock, Bradford; Messrs. Ward and Son, Brompton; Dr. Williams, London; Dr. Tomkins, Monsall; Mr. North, York; Mr. Lovegrove, Wallerton; Mr. Mayland, Glasgow; Mr. Townsend, Exeter; Mr. Byfield; Mr. White, Bayswater; Messrs. Millikin and Down; Mrs. Took, Great Berkhampstead; Messrs. Barker and Co., Huddersfield; Mr. Ronse, Bayswater; Mr. Pope, Pinner; Mr. Gee, Southwell; Mr. Whitley, Halifax; Mr. Lark, Hingham; Dr. Powell, Newcastle-on-Tyne; Mr. Edmunds, Chesterfield; Dr. Thomas, Christchurch, New Zealand; Dr. Foote, Rotherham; Dr. Miller, Reading; Dr. C. Hewett, London; Mr. Pile, Salisbury; Dr. Allen, Grimsby; X.; Surgeon-Major, Dublin; M. P. D., Liverpool; J. G., Bloomsbury; Assistant, Liverpool; Medicus, Dartmouth park; Tenax, London; Principal, Seaford; Perilas, Exeter; L. C.; Beta, Manchester; C.; M. Z.; Home; Miss H., Oldham; Medical, Castleford; A. B.; J. R., Fence Houses; Albus, Holborn; E. F.; Medicus, Nottingham; G., Manchester; Principal, Seaford; Tenax Propositi; W.; A. B.; D. T., St. Helens; Alpha, Farringdon; C. R., Wandsworth; A. C. K., St. John's-wood; X. Y. Z., London; Medicus, Margate; C. J. A.; K. A., Clapham; F.R.C.S., Leeds; A. B. C., Paddington; H. F. D.; Medicus, Liverpool; Medicus, Birmingham; Medicus, Milford Haven; &c. &c.

Parkstone Reminder, Carnarvon and Denbigh Herald, St. Pancras Gazette, &c., have been received.

Medical Diary for the ensuing Week.

Monday, Oct. 30.

ROYAL LONDON OPHTHALMIC HOSPITAL, MOORFIELDS.—Operations, 10½ A.M. each day, and at the same hour.

ROYAL WESTMINSTER OPHTHALMIC HOSPITAL.—Operations, 1½ P.M. each day, and at the same hour.

METROPOLITAN FREE HOSPITAL.—Operations, 2 P.M.

ROYAL ORTHOPÆDIC HOSPITAL.—Operations, 2 P.M.

ST. MARK'S HOSPITAL.—Operations, 2 P.M.; on Tuesday, 9 A.M.

MEDICAL SOCIETY OF LONDON.—8.30 P.M. Dr. C. Theodore Williams, "On a Case of Paracentesis Pulmonis."—Dr. Leonard W. Sedgwick will communicate a paper by Dr. Richard Schmitz (Neuenahr), "On 600 Cases of Diabetes Mellitus."

Tuesday, Oct. 31.

GUY'S HOSPITAL.—Operations, 1½ P.M., and on Friday at the same hour.

WESTMINSTER HOSPITAL.—Operations, 2 P.M.

WEST LONDON HOSPITAL.—Operations, 3 P.M.

Wednesday, Nov. 1.

NATIONAL ORTHOPÆDIC HOSPITAL.—Operations, 10 A.M.

MIDDLESEX HOSPITAL.—Operations, 1 P.M.

ST. BARTHOLOMEW'S HOSPITAL.—Operations, 1½ P.M., and on Saturday at the same hour.

ST. THOMAS'S HOSPITAL.—Operations, 1½ P.M., and on Saturday at the same hour.

ST. MARY'S HOSPITAL.—Operations, 1½ P.M.

LONDON HOSPITAL.—Operations, 2 P.M., and on Thursday and Saturday at the same hour.

GREAT NORTHERN HOSPITAL.—Operations, 2 P.M.

SAMARITAN FREE HOSPITAL FOR WOMEN AND CHILDREN.—Operations, 2½ P.M.

UNIVERSITY COLLEGE HOSPITAL.—Operations, 2 P.M., and on Saturday at the same hour.—Skin Department: 1.45 P.M., and on Saturday at 9.15 A.M.

EPIDEMIOLOGICAL SOCIETY OF LONDON.—8 P.M. Dr. Norman Chevers, "On the Sanitary Defects of the Site of London and its Suburbs."

OBSTETRICAL SOCIETY OF LONDON.—8 P.M. Specimens will be shown by Mr. Alban Doran and others.—Dr. Champneys, "On a Description of a Kyphotic Pelvis, with remarks on Breisky's Description."—Dr. Matthews Duncan, "On Puerperal Diabetes."—Dr. Chahbazian, "On the Treatment of Post-partum Hæmorrhage by Subcutaneous Injection of Ergotinine."

Thursday, Nov. 2.

ST. GEORGE'S HOSPITAL.—Operations, 1 P.M.

ST. BARTHOLOMEW'S HOSPITAL.—1½ P.M. Surgical Consultations.

CHARING-CROSS HOSPITAL.—Operations, 2 P.M.

CENTRAL LONDON OPHTHALMIC HOSPITAL.—Operations, 2 P.M., and on Friday at the same hour.

HOSPITAL FOR WOMEN, SOHO-SQUARE.—Operations, 2 P.M.

NORTH-WEST LONDON HOSPITAL.—Operations, 2½ P.M.

HARVEIAN SOCIETY.—8.30 P.M. Mr. Malcolm Morris, "On Chronic Ringworm."—Dr. Broadbent, "On some Points relating to the Sounds of the Heart."

Friday, Nov. 3.

ST. GEORGE'S HOSPITAL.—Ophthalmic Operations, 1½ P.M.

ST. THOMAS'S HOSPITAL.—Ophthalmic Operations, 2 P.M.

ROYAL SOUTH LONDON OPHTHALMIC HOSPITAL.—Operations, 2 P.M.

KING'S COLLEGE HOSPITAL.—Operations, 2 P.M.

Saturday, Nov. 4.

KING'S COLLEGE HOSPITAL.—Operations, 1 P.M.

ROYAL FREE HOSPITAL.—Operations, 2 P.M.

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